

A BILL

4
5 In recognition of the essential role that covered individuals, air traffic controllers, flight
6 attendants, maintenance technicians, dispatchers, aviation medical professionals, veterans,
7 and families play in maintaining the safety and integrity of the national airspace—and in
8 response to growing concerns over coercive, unscientific, and rights-infringing practices
9 within the FAA’s medical certification and monitoring systems—Congress enacts this
10 legislation.

11
12 To uphold aviation safety through the restoration of scientific integrity, civil liberties, and
13 due process in the Federal Aviation Administration’s medical certification process; to
14 establish independent oversight, modernized procedures, and fair treatment for all airmen,
15 aviation professionals, and medical providers; and to ensure that no individual is subjected
16 to coercive, unvalidated, or discriminatory practices under the guise of medical regulation.

17
18 *Be it enacted by the Senate, and House of Representatives of the United States of America in*
19 *Congress assembled,*
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124 **TITLE I — SHORT TITLE AND FINDINGS**

125 **SEC. 101. SHORT TITLE.**

126 a. This Act may be cited as the “Pilots for HIMS Reform Act of 2026.”

127 **SEC. 102. FINDINGS.**

- 128 1. The FAA’s Human Intervention Motivation Study (HIMS) Program has operated for
129 over four decades with no independent regulatory oversight or scientific validation.
- 130 2. The structure of the HIMS Program — involving coordination among the FAA,
131 employers, and covered individual unions — has created significant conflicts of
132 interest that undermine covered individual autonomy and due process.
- 133 3. Covered individuals are often subject to prolonged monitoring, coercive treatment
134 mandates, and costly evaluations based not on individualized medical risk but on
135 rigid, outdated protocols.
- 136 4. Participation in the HIMS Program is frequently compelled under threat of
137 employment termination or indefinite grounding, even when there is no current
138 impairment or valid medical basis for intervention.
- 139 5. The FAA’s reliance on spiritual or 12-step recovery frameworks, and its refusal to
140 accept equivalent scientific models, imposes religious burdens and limits access to
141 alternative forms of treatment.
- 142 6. Covered individuals often face arbitrary denials, hidden internal memos, and secret
143 FAA medical determinations with no opportunity for rebuttal or appeal.
- 144 7. FAA contractors and union-affiliated physicians are not subject to sufficient
145 oversight, and their evaluations often go unchallenged despite conflicts of interest
146 and a lack of accountability.
- 147 8. The mental health and substance use evaluation system has become a punitive and
148 opaque process that discourages covered individuals from seeking help or self-
149 reporting concerns.

- 150 9. Covered individuals have been unjustly delayed in certification, denied basic rights,
151 and subjected to indefinite surveillance based on stigma, not science.
- 152 10. Despite repeated opportunities and widespread reports of harm, the FAA has failed
153 to implement meaningful internal reform of the HIMS Program or its broader
154 medical certification practices.
- 155 11. The current system fails to provide transparency, consistency, or fairness —
156 threatening not only individual livelihoods but public trust in FAA medical
157 oversight.
- 158 12. Thousands of covered individuals have participated in monitoring programs in good
159 faith, yet continue to face stigma and indefinite oversight without evidence of
160 relapse or risk.

161 **SEC. 103. PURPOSE AND LEGISLATIVE INTENT.**

- 162 1. Establish a transparent, science-based, and rights-respecting framework for the
163 medical evaluation of covered individuals with mental health or substance use
164 histories.
- 165 2. Eliminate coercive, monopolized recovery programs and create an alternative
166 pathway (AEROPath) grounded in evidence, ethics, and autonomy.
- 167 3. Guarantee airmen timely access to their medical records, real-time case status, and
168 an impartial appeal process through independent review.
- 169 4. Prohibit discrimination, religious coercion, and financial exploitation within FAA
170 medical certification.
- 171 5. Restore due process for all covered individuals — union and non-union — and
172 ensure equal treatment for mental and physical health conditions.
- 173 6. Protect whistleblowers, safeguard covered individual privacy, and increase
174 accountability for FAA contractors and medical designees.
- 175 7. Fully sunset the legacy HIMS Program and transition all monitoring functions to
176 AEROPath — a model that respects the dignity, rights, and humanity of those who
177 fly.

178 8. Enhance aviation safety by restoring covered individual trust, encouraging early
179 self-reporting, and ensuring that only scientifically valid risks lead to certification
180 action.

181 9. Align FAA policy with the principles of the Americans with Disabilities Act, the
182 Rehabilitation Act, and modern disability rights standards.

183 **SEC. 104. HUMAN DIGNITY AND RESPECT.**

184 All individuals subject to FAA medical oversight — including pilots, student pilots,
185 air traffic controllers, mechanics, flight attendants, medical professionals, and any
186 others covered under this Act — shall be treated with dignity, fairness, and
187 compassion.

188 Programs and enforcement mechanisms affected by this Act must operate in a
189 manner that avoids humiliation, coercion, or excessive burden and must uphold the
190 rights, recovery, and humanity of every person involved.

191 No safety interest shall be construed to override the basic dignity or civil liberties of
192 individuals subject to medical evaluation or certification.

193 **TITLE II — FAA MEDICAL CERTIFICATION REFORM**

194 **SEC. 201. DUE PROCESS REQUIREMENTS FOR SPECIAL ISSUANCE.**

195 a. The FAA shall not deny, delay, modify, or revoke a special issuance medical certificate
196 without:

197 1. Written notice to the covered individual stating the specific reason(s) for the action,

198 2. Disclosure of all evidence or reports relied upon, and

199 3. A reasonable opportunity for the covered individual to respond and provide
200 rebuttal documentation or medical opinion.

201 b. Any adverse FAA action must be based on verifiable, documented medical evidence and
202 not on:

203 1. Anonymous reports,

- 204 2. Third-party hearsay, or
- 205 3. Informal communications not disclosed to the airman.
- 206 c. Covered individuals shall have the right to request a copy of their full FAA medical file,
207 including internal communications, contractor evaluations, and any medical narrative
208 used to justify certification decisions. This request shall be fulfilled within 30 days.
- 209 d. The FAA may not impose blanket requirements or generalized risk assumptions; all
210 determinations must be individualized and evidence-based.

211 **SEC. 202. INDEPENDENT REVIEW OF MEDICAL DENIALS.**

- 212 a. Establishment of Independent Medical Review Board (IMRB).
- 213 1. The FAA shall create an Independent Medical Review Board (IMRB) to review
214 contested aeromedical decisions. The IMRB shall consist of:
- 215 a. One board-certified psychiatrist with expertise in addiction or occupational
216 medicine,
- 217 b. One independent aeromedical specialist not affiliated with the FAA, unions, or
218 air carriers,
- 219 c. One clinician selected by the covered individual, who may be the covered
220 individual's treating physician, psychologist, or a qualified independent
221 evaluator.
- 222 b. Scope of review.
- 223 1. The IMRB shall have full access to the covered individual's medical record and all
224 documentation relied upon by the FAA. The IMRB shall assess:
- 225 a. The scientific basis of the FAA's action,
226 b. Procedural fairness and transparency, and
227 c. Conformity with DSM-5-TR criteria and evidence-based clinical guidelines.
- 228 c. Decision and enforcement.
- 229 1. The IMRB shall issue a written decision within 45 calendar days. If the IMRB finds
230 the FAA's action to be unjustified, the FAA shall:
- 231 a. Immediately reverse the denial or modify the Special Issuance accordingly,
232 b. Remove any related adverse records from the covered individual's file, and
233 c. Refrain from imposing further action based on the same underlying evidence.
- 234 d. FAA override limitation.

- 235 1. The FAA may only override the IMRB's decision by demonstrating, through clear
236 and convincing evidence, that granting certification would pose an imminent threat
237 to public safety.
- 238 2. Any such override must be approved by the Federal Air Surgeon and reported to
239 Congress within 30 days.
- 240 3. The FAA must provide a written explanation that:
241 a. Describes the objective clinical or operational data relied upon,
242 b. References specific findings indicating imminent risk,
243 c. Is made available to the IMRB and IAMOC for immediate post-action review.
- 244 4. Repeated or systemic use of the override provision without IMRB concurrence shall
245 trigger an investigation by IAMOC and referral to the DOT Inspector General.
- 246 e. Universal eligibility.
- 247 1. These rights shall apply equally to:
248 a. Union and non-union covered individuals,
249 b. Covered individuals flying under Part 121, 135, or 91,
250 c. General aviation covered individuals,
251 d. Corporate and contract covered individuals, and
252 e. Former military covered individuals seeking civilian certification.
- 253 f. Expedited review and emergency appeals.
- 254 1. Covered individuals facing immediate employment impact, grounding, or financial
255 harm due to FAA inaction or adverse decisions shall have the right to request
256 expedited review by the IMRB.
- 257 2. Upon receipt of a valid request demonstrating urgency, the IMRB shall render a
258 preliminary decision within 10 business days, which may include a stay of
259 enforcement.
- 260 3. The FAA shall not suspend or revoke a certificate based on contested information
261 during the pendency of an emergency appeal unless required to address a
262 confirmed safety risk.
- 263 g. Reporting and transparency requirements.
- 264 1. The IMRB shall publish an annual report summarizing:
265 a. Total number of appeals submitted,
266 b. Average resolution time,
267 c. Outcomes (granted, denied, modified), and

- 268 d. Any cases overridden by the FAA with justification.
- 269 2. This report shall be delivered to the House and Senate Committees on
- 270 Transportation and made publicly available via the FAA website.
- 271 3. Individual covered individual names or identifying details shall not be disclosed;
- 272 data shall be anonymized and aggregated to protect privacy.

273 **SEC. 203. MANDATORY FAA RESPONSE TIMELINES AND ENFORCEMENT.**

- 274 a. Time limits for FAA medical certification determinations.
 - 275 1. The FAA shall issue a decision on all applications for first-, second-, or third-class
 - 276 medical certification, including Special Issuance requests, within the following
 - 277 timeframes:
 - 278 a. Initial Application: 60 calendar days from date of complete application
 - 279 submission.
 - 280 b. Follow-Up Requests: 30 calendar days from date of receipt of all supplemental
 - 281 information requested by the FAA.
 - 282 c. Special Issuance Renewal: 30 calendar days from submission of annual
 - 283 monitoring or treatment records, provided no new adverse findings are
 - 284 reported.
 - 285 b. Interim approval for delayed cases.
 - 286 1. If the FAA fails to render a decision within the timeframes specified in subsection
 - 287 (a), and there is no documented evidence of imminent risk to flight safety, the
 - 288 covered individual shall be granted temporary medical certification for 120 days or
 - 289 until the case is resolved, whichever comes first.
 - 290 c. Tolling prohibited without justification.
 - 291 1. The FAA may not delay, pause, or “toll” a certification decision unless:
 - 292 a. It notifies the covered individual in writing within the original deadline, and
 - 293 b. Provides a specific, case-related justification (e.g., pending third-party records,
 - 294 incomplete test results).
 - 295 d. Enforcement and penalties for delay.
 - 296 1. If the FAA exceeds a deadline by more than 30 days without justification, the
 - 297 covered individual may submit a delay complaint to the IMRB or the Independent
 - 298 Oversight Council (IAMOC).

- 299 2. If the FAA is found to have engaged in unnecessary delay, the airman shall be
300 entitled to:
- 301 a. Immediate expedited review,
302 b. Reimbursement for medical or legal costs incurred due to the delay, and
303 c. Statutory damages up to \$10,000 for employment or financial harm suffered.
- 304 3. Persistent or systemic delay patterns shall be investigated by the DOT Inspector
305 General and may result in administrative sanctions against FAA Aeromedical
306 leadership.
- 307 e. Annual certification processing report.
- 308 1. The FAA shall publish an Annual Aeromedical Certification Performance Report that
309 includes:
- 310 a. Average and median processing times for initial certifications and Special
311 Issuances,
312 b. Total number of certifications delayed beyond statutory deadlines,
313 c. Common delay reasons categorized by case type,
314 d. Corrective actions taken to improve processing time.
- 315 2. This report shall be submitted to the House and Senate Committees on
316 Transportation and posted on the FAA's public website.

317 **SEC. 204. ADDITIONAL PROTECTIONS IN CERTIFICATION PROCESS.**

- 318 a. Prohibition on retroactive changes to medical certification.
- 319 1. The FAA may not retroactively revise, revoke, or alter the terms of a previously
320 issued medical certificate or Special Issuance without:
- 321 a. Written notice to the covered individual,
322 b. A specific explanation of the medical or regulatory basis, and
323 c. An opportunity to appeal the decision through the IMRB prior to enforcement.
- 324 2. No retroactive enforcement action or employment notification may occur unless the
325 covered individual has been given due process under this section.
- 326 b. Official case activity logging and auditability.
- 327 1. FAA shall maintain a structured digital log for every covered individual undergoing
328 aeromedical review. The log shall include:
- 329 a. All deferrals, denials, approvals, and correspondence,
330 b. The name or office of the responsible FAA official,

- 331 c. Date and time of each action, and
332 d. A brief statement of the reason for the action.
- 333 2. This log shall be accessible to the covered individual through the FAA's secure
334 online portal as required under Section 501(d).
- 335 3. The DOT Inspector General and IAMOC shall have full access to all case logs for audit
336 purposes.
- 337 c. Right to representation without prejudice.
- 338 1. Covered individuals shall have the right to be represented by legal counsel, union
339 representative, or designated independent advocate at any stage of the medical
340 certification process, including during:
- 341 a. Communication with FAA medical personnel,
342 b. Reviews by the IMRB or IAMOC, and
343 c. Submission of rebuttal documentation.
- 344 2. The FAA shall not draw adverse inference from a covered individual's decision to
345 obtain representation, nor may it retaliate or delay certification on that basis.
- 346 d. Protection against repetitive or vague documentation requests.
- 347 1. The FAA shall issue a single, comprehensive request for all additional
348 documentation it deems necessary within 30 calendar days of receipt of a medical
349 application or renewal.
- 350 2. No further documentation requests may be made unless new material facts arise or
351 the covered individual voluntarily submits new information.
- 352 3. Requests must be specific and medically justified; vague, open-ended, or redundant
353 demands shall be deemed non-compliant with this section and subject to IMRB
354 review upon complaint.
- 355 e. Equal weight for treating physician reports.
- 356 1. The FAA shall give equal evidentiary weight to medical reports and opinions issued
357 by the covered individual's treating physician, psychologist, or psychiatrist.
- 358 2. Reports may only be discounted if the FAA identifies a documented, case-specific
359 clinical concern or conflict of interest.
- 360 3. No adverse action shall be taken against a covered individual based on
361 disagreement between internal FAA consultants and a qualified treating provider
362 unless objective evidence justifies doing so.

363 **SEC. 205. TIME-LIMITED RESOLUTION OF MEDICAL APPEALS**

- 364 a. Timeframe for Appeal Resolution.
- 365 1. All formal appeals submitted under this Act, including those reviewed by IAMOC or
- 366 a designated FAA review entity, shall be resolved within:
- 367 a. 60 calendar days for standard individual case appeals;
- 368 b. 90 calendar days if additional clinical consultation or external evaluation is
- 369 necessary.
- 370 2. The appeal timeline shall begin upon receipt of all required documentation from the
- 371 appellant or their authorized representative.
- 372 3. IAMOC may grant a single extension of no more than 30 calendar days, but only
- 373 upon a written finding that the delay is necessary for national security, public safety,
- 374 or to complete a required medical consultation.
- 375 b. Optional Medical Certification Appeals Panel.
- 376 1. IAMOC may, at its discretion, refer an appeal to a Medical Certification Appeals
- 377 Panel composed of:
- 378 a. One licensed FAA-affiliated medical representative,
- 379 b. One licensed HIMS AME, psychiatrist, or neuropsychologist with subject matter
- 380 expertise,
- 381 c. One certified covered individual or air traffic controller representative not
- 382 currently involved in the case.
- 383 2. The panel must issue a written decision or recommendation within the timeline
- 384 specified in subparagraph a.1.a.

385 **SEC. 206. AUTOMATIC ESCALATION AND RELIEF FOR FAA DELAY.**

- 386 a. Time Limit for Determination.
- 387 1. The FAA shall issue a final decision on any covered individual's medical certification
- 388 or recertification request within 90 calendar days of receiving a complete
- 389 submission, including all requested documentation.
- 390 b. Automatic Escalation.
- 391 1. If no final decision is issued within the time frame:
- 392 a. The case shall be automatically escalated to the Federal Air Surgeon or designee
- 393 for expedited resolution; and
- 394 b. The covered individual shall have the right to immediately petition the IMRB for
- 395 review under Section 202, without waiting for FAA closure.
- 396 c. Temporary Relief.

- 397 1. A covered individual with no disqualifying event in the preceding 12 months and a
398 previously valid certificate may request that the IMRB grant a temporary
399 reinstatement pending resolution. The IMRB may authorize such relief based on a
400 showing of good cause.
- 401 d. Notice Requirement.
- 402 1. The FAA shall notify the covered individual in writing no later than calendar day 91
403 of their right to escalate under this section.
- 404 e. Exemption for Applicant Fault.
- 405 1. This section shall not apply where the FAA demonstrates that the delay was caused
406 by materially incomplete, inaccurate, or fraudulent submissions by the applicant.

407 **TITLE III — SCIENTIFIC INTEGRITY AND OVERSIGHT**

408 **SEC. 301. AEROPATH COVERED INDIVIDUAL EVALUATION ALTERNATIVE.**

- 409 a. The FAA shall fund, implement, and authorize an alternative to the HIMS program
410 known as the Aviation Evaluation and Recovery Oversight Pathway (AEROPath) for
411 covered individuals subject to medical monitoring or recovery review.
- 412 b. AEROPath shall operate independently of air carriers, covered individual unions, and
413 FAA administrative staff. It shall be governed by a rotating AEROPath Oversight Board,
414 composed of:
- 415 1. 1 licensed clinical psychologist with aviation experience,
416 2. 1 board-certified addiction medicine physician,
417 3. 1 civil liberties or disability rights advocate,
418 4. 1 public health data scientist,
419 5. 2 covered individuals who have completed FAA medical monitoring within the past
420 10 years, and
421 6. 1 rotating non-voting member appointed by the FAA.
422 7. 1 currently designated HIMS-certified AME with at least five years of clinical
423 experience, selected by a vote of individuals from the aviation community who have
424 participated in FAA medical monitoring or certification oversight in the past 10
425 years. This AME shall:
- 426 a. Be unaffiliated with any airline, covered individual union, or FAA contract for at
427 least three years,
428 b. Serve as a full voting member of the AEROPath Oversight Board,

- 429 c. Be nominated through a covered individual-organized selection process and
430 reconfirmed after each term,
- 431 d. Submit annual public disclosures regarding conflicts of interest.
- 432 c. AEROPath shall allow flexible, science-based monitoring models, including:
- 433 1. Cognitive Behavioral Therapy (CBT),
434 2. Medication-Assisted Treatment (MAT),
435 3. Professional coaching or non-religious peer support,
436 4. Structured recovery plans individualized by risk and condition.
- 437 d. No participation in 12-step, religious, or spiritually based recovery frameworks may be
438 required under AEROPath. These options may be offered only upon voluntary selection
439 by the covered individual.
- 440 e. AEROPath eligibility shall be available to:
- 441 1. Any covered individual undergoing FAA review for a mental health, substance use,
442 or behavioral condition,
443 2. Any current or past HIMS participant, regardless of program stage,
444 3. Covered individuals in commercial, corporate, general aviation, and military-to-
445 civilian transition roles.
- 446 f. Covered individual opt-in and transition clause.
- 447 1. Covered individuals currently enrolled in HIMS shall have the right to opt into
448 AEROPath by submitting a written request.
449 2. All time served in HIMS monitoring shall be fully credited toward AEROPath
450 milestones.
451 3. No covered individual may be penalized for transitioning from HIMS to AEROPath.
452 4. Within 18 months of enactment, the FAA shall establish standardized procedures for
453 this transition and publish guidance for AMEs, employers, and covered individuals.
- 454 g. Implementation timeline.
- 455 1. The FAA shall launch AEROPath within 12 months of enactment of this Act.
456 2. AEROPath shall accept covered individual transitions from HIMS no later than 18
457 months post-enactment.
458 3. The FAA shall cease new HIMS enrollments within 24 months, unless the covered
459 individual specifically opts into the legacy model.
- 460 h. Outcome reporting and program evaluation.

- 461 1. The AEROPath Oversight Board shall collect and report annual, anonymized data to
462 assess program performance, safety impact, and treatment efficacy. These reports
463 shall include:
- 464 a. Total number of covered individuals enrolled, released, or transitioned from
465 HIMS,
 - 466 b. Average monitoring duration by condition and risk level,
 - 467 c. Rate of adverse incidents during or after monitoring (e.g., positive tests, relapse,
468 enforcement action),
 - 469 d. Rate of successful medical certification reinstatement and return to duty,
 - 470 e. Comparison of outcomes between AEROPath and legacy HIMS participants.
- 471 2. Reports must be made publicly available and submitted to:
- 472 a. The FAA Administrator,
 - 473 b. House and Senate Committees on Transportation,
 - 474 c. The DOT Inspector General.
- 475 3. Covered individual identities must be anonymized and reported in aggregate. No
476 personally identifiable information shall be disclosed under any circumstance.
- 477 4. The Oversight Board shall also issue biennial recommendations for program
478 improvement based on treatment science, covered individual feedback, and ethical
479 guidelines.
- 480 5. The FAA may not impose additional requirements or restrict AEROPath access
481 based on program statistics without:
- 482 a. Written rationale reviewed by the Oversight Board, and
 - 483 b. Publication of justification in the Federal Register.

484 **SEC. 302. SCIENTIFIC STANDARDS FOR DIAGNOSIS AND MONITORING.**

- 485 a. Any diagnosis of a disqualifying mental health or substance use condition must:
- 486 1. Meet prevailing DSM criteria,
 - 487 2. Be documented in a signed report by a licensed medical professional or
488 psychologist, and
 - 489 3. Include a clinical explanation of how the condition may affect aviation safety.
- 490 b. FAA-imposed monitoring must:
- 491 1. Be based on individualized clinical risk, not diagnostic label alone,
 - 492 2. Include clear duration, scope, and exit criteria,

- 493 3. Not exceed 36 months unless the covered individual has experienced a confirmed
494 relapse,
- 495 4. Allow for early release or step-down based on progress, and new medical opinions.
- 496 c. Testing protections:
- 497 1. All testing must allow split samples, and DNA verification.
- 498 2. Covered individuals must receive results within seven days.
- 499 3. No adverse action may occur until confirmatory testing is complete.
- 500 d. No covered individual shall be required to obtain or maintain a Special Issuance based
501 solely on a drug or alcohol-related offense that occurred more than 5 years prior,
502 provided the covered individual has not experienced any subsequent relapse, legal
503 event, or clinical impairment. All covered individuals currently holding an SI on this
504 basis shall be eligible for full restoration of unrestricted certification.
- 505 e. The FAA shall not authorize or accept third-party testing orders or reports unless:
- 506 1. The covered individual has signed written consent for each specific interaction, and
507 2. Clinical justification for each test or monitoring event is documented, and
508 reviewable.
- 509 f. Notification, Scheduling, and Retaliation Protections in Testing.
- 510 1. Reasonable Notification Required.
- 511 No testing administrator, monitoring entity, or designated physician shall issue any
512 testing notification or assignment with less than twenty-four (24) hours' advance
513 notice, except in documented exigent circumstances posing an imminent threat to
514 public safety.
- 515 2. Right to Declare Unavailability.
- 516 Covered individuals shall have the right to submit in advance a schedule of
517 anticipated unavailability due to:
- 518 a. Work assignments or duty periods;
- 519 b. Employer-approved leave or vacation; or
- 520 c. Personal travel or vacation undertaken during scheduled days off.
- 521 Such declarations shall be accepted and presumed valid absent clear and convincing
522 evidence of fraud or misrepresentation.
- 523 3. Duty to Accommodate Bona Fide Conflicts.
- 524 If a covered individual notifies the monitoring entity within twenty-four (24) hours
525 of receiving a testing notification that the scheduled date or time conflicts with a

526 declared period of unavailability or a bona fide emergency, the monitoring entity
527 shall:

- 528 a. Provide an alternative testing date within five (5) calendar days; or
- 529 b. Permit testing at a comparable collection site proximate to the covered
530 individual's location.

531 4. Safe Harbor for Non-Accommodated Conflicts.

532 If the monitoring entity fails to provide an alternative testing opportunity within the
533 time period specified in paragraph (3), the original testing assignment shall be
534 deemed invalid and unenforceable, and no adverse inference or sanction may result.

535 5. Prohibition on Retaliation.

- 536 a. No testing assignment may be issued or modified in retaliation for:
 - 537 (1) Filing any complaint, grievance, or appeal related to monitoring practices;
 - 538 (2) Raising concerns about compliance irregularities or procedural fairness; or
 - 539 (3) Exercising any right established by this Act.

540 6. Time Zone Clarification.

541 All notices and deadlines under this subsection shall be calculated based on the
542 covered individual's primary residence time zone.

543 7. Penalties for Repeated Violations.

544 Repeated or intentional violations of this subsection by any monitoring entity or
545 testing administrator shall result in suspension or revocation of authority to
546 conduct FAA-related monitoring and may result in civil penalties not to exceed
547 \$25,000 per occurrence.

548 8. Documentation of Testing Notifications.

- 549 a. All testing notifications under this subsection shall be issued in writing, time-
550 stamped, and retained for a minimum of five (5) years. Notifications must
551 include:
 - 552 (1) The specific date and time the notice was sent;
 - 553 (2) The testing location and time;
 - 554 (3) The method of delivery; and
 - 555 (4) Instructions for declaring unavailability.

556 9. Emergencies Occurring After Notification.

557 Covered individuals may assert a bona fide personal or family emergency arising

558 after a testing notification. Such emergencies shall be accommodated upon
559 reasonable evidence provided within ten (10) calendar days.

560 10. Limit on Test Frequency.

561 a. Absent documented exigent circumstances, no covered individual shall be
562 assigned more than one (1) random testing event within any rolling seven (7)
563 calendar day period.

564 11. Expedited Complaint and Relief.

565 Covered individuals may submit an expedited complaint regarding any testing
566 notification or scheduling conflict to the Independent Medical Review Board (IMRB)
567 or IAMOC. Upon receipt, the IMRB or IAMOC shall issue interim findings or relief
568 within fourteen (14) calendar days.

569 12. Definition of Exigent Circumstances.

570 a. "Exigent circumstances," as used in this subsection, means credible, documented
571 evidence of imminent substance use or impairment creating a direct risk to
572 aviation safety.

573 **SEC. 303. OVERSIGHT AND ACCOUNTABILITY FOR LEGACY FAA MONITORING**
574 **PROVIDERS.**

575 a. Public disclosure requirement.

576 1. The FAA shall maintain a public, searchable database listing all providers formerly
577 affiliated with the HIMS Program or any legacy FAA-mandated monitoring system
578 for covered individuals.

579 2. Each entry shall include:

- 580 a. Name and credentials,
- 581 b. Location and years of affiliation,
- 582 c. Disclosed financial conflicts of interest,
- 583 d. History of formal complaints or sanctions, if any.

584 3. This requirement shall apply during the transition period defined in Section 504 and
585 remain in effect for five years from enactment.

586 b. Provider audit and decertification.

587 1. The FAA shall require all legacy-affiliated monitoring providers to submit to regular
588 audits conducted by the DOT Inspector General or an independent review entity.

589 2. Grounds for decertification include:

- 590 a. Coercive or punitive treatment practices,
591 b. Financial kickbacks or dual-agency conflicts,
592 c. Denial of covered individual rights protected under this Act.
- 593 3. Providers found in violation shall be immediately suspended from receiving any
594 FAA-related referrals pending investigation.
- 595 c. Restrictions on FAA Influence Over Medical Professionals.
- 596 1. The FAA may not direct or pressure an AME or clinician to adopt a specific course of
597 treatment, deferment, or monitoring recommendation.
- 598 2. All AME recommendations must be made independently, in the best interest of
599 aviation safety and the covered individual, and based on clinical evidence.
- 600 3. Covered individuals shall have the right to report any undue FAA interference to the
601 Independent Medical Review Board (IMRB) or the Independent Oversight Council
602 (IAMOC) for investigation.
- 603 d. No Circumvention via Safety Concern Language.
- 604 1. No covered individual shall be subject to mandatory treatment, evaluation, or
605 monitoring solely on the basis of:
- 606 a. Vague or non-clinical safety justifications;
607 b. Observed “attitude,” “resistance,” or “lack of insight”; or
608 c. Prior program participation, absent a new qualifying event.
- 609 2. Any imposed action must be based on current clinical evidence meeting DSM-5-TR
610 or FAA regulatory criteria and must be documented in writing. Safety concerns
611 alone shall not justify override of Sections 301 through 303 protections.

612 **SEC. 304. BURDEN OF EVIDENCE AND SCIENTIFIC JUSTIFICATION.**

- 613 a. Burden of Proof.
- 614 1. The FAA, its contractors, or designees shall bear the burden of proving that
615 any medical restriction, Special Issuance condition, or monitoring
616 requirement is based on:
- 617 a. Documented medical findings,
618 b. A current diagnosis meeting DSM-5-TR or FAA criteria, or
619 c. Objective risk factors supported by peer-reviewed evidence.
- 620 b. No Presumption of Impairment.

- 621 1. No covered individual shall be presumed impaired or in need of monitoring
622 absent evidence meeting subsection (a). Past participation in treatment or
623 monitoring alone shall not justify future restrictions.
- 624 c. Evaluations Must Be Justified.
- 625 1. Any ordered evaluation, including neuropsychological or substance use
626 assessments, must include a written statement of clinical need and
627 relevance. Statements based solely on concern, tone, or perceived resistance
628 shall be deemed insufficient.
- 629 d. Right to Challenge.
- 630 1. Covered individuals shall have the right to challenge any imposed condition
631 under Section 202 and may demand that the FAA disclose the scientific basis
632 for the decision.

633 **TITLE IV — AIRMAN RIGHTS AND SAFEGUARDS**

634 **SEC. 401. FIRST AMENDMENT AND RELIGIOUS NEUTRALITY.**

- 635 a. No covered individual shall be required to affirm or deny religious belief as a condition
636 of medical certification or program participation.
- 637 b. The FAA and its agents may not impose or recommend participation in any program
638 requiring acknowledgment of a higher power or spiritual surrender.
- 639 c. The FAA may not deny or delay certification on the grounds that a covered individual
640 has declined to participate in 12-step, spiritually based, or faith-affiliated recovery
641 programs.

642 **SEC. 402. WHISTLEBLOWER PROTECTIONS.**

- 643 a. Covered individuals, AMEs, clinicians, or any individuals who report abuse, coercion,
644 policy violations, or conflicts of interest shall be protected from retaliation.
- 645 b. Retaliation includes, but is not limited to:
- 646 1. Negative FAA case flagging;
- 647 2. Denial of certification on pretextual grounds;
- 648 3. Employer reporting or referrals tied to protected speech;
- 649 4. Deliberate case slowdowns or documentation burdens.
- 650 c. The FAA shall establish a confidential reporting mechanism, administered by the
651 Independent Oversight Council (IAMOC), to investigate all retaliation complaints.

- 652 d. Whistleblowers subjected to retaliation shall be entitled to:
- 653 1. Immediate case freeze and review;
- 654 2. Reinstatement of certificate or medical privileges;
- 655 3. Damages up to \$250,000 and reimbursement for all legal and medical costs
- 656 incurred.

657 **SEC. 403. SCIENTIFIC RIGHTS, FALSE POSITIVES, AND LABORATORY ERROR**

658 **PROTECTIONS.**

- 659 a. Confirmatory Testing and DNA Verification Rights.
- 660 1. Covered individuals receiving a positive test result shall have the right to:
- 661 a. Access a properly preserved split sample;
- 662 b. Select and request independent confirmatory analysis from a laboratory of equal
- 663 or higher accreditation;
- 664 c. Request DNA verification of the sample;
- 665 d. Receive a full laboratory report within five business days, including:
- 666 (1) Testing methodology and cutoff thresholds,
- 667 (2) Chain-of-custody documentation,
- 668 (3) Substances screened and laboratory personnel identifiers;
- 669 e. Contact information for the testing facility;
- 670 f. Written instructions on how to request confirmatory testing or DNA
- 671 comparison;
- 672 g. A minimum of five (5) business days from notice of the result to initiate
- 673 confirmatory testing or DNA verification. During this time:
- 674 (1) No enforcement, reporting, or presumption of use or impairment may occur;
- 675 (2) Any action taken in this window shall be deemed procedurally invalid.
- 676 b. Suspension of Enforcement Pending Scientific Review.
- 677 1. The FAA, employer, or monitoring program shall suspend all enforcement actions,
- 678 including deferral, grounding, or Special Issuance modification;
- 679 2. No presumption of substance use, impairment, or noncompliance may be made;
- 680 3. The covered individual may retain an independent expert to review and submit
- 681 findings into the FAA record;
- 682 4. Failure to suspend enforcement shall entitle the covered individual to:
- 683 a. Immediate IMRB review,

- 684 b. Tolling of all deadlines or monitoring actions,
685 c. Statutory damages of no less than \$10,000.
- 686 c. Scientific Validity and Evidentiary Standards.
- 687 1. No adverse action shall be taken unless:
- 688 a. Scientific certainty (at least 95% confidence) is established that:
- 689 (1) The substance was present in the covered individual's body,
690 (2) The result reflects actual ingestion, not contamination or passive exposure,
691 (3) Chain of custody was unbroken and fully documented;
- 692 b. The test was performed by a laboratory holding current SAMHSA, CLIA, or CAP
693 accreditation;
- 694 c. The FAA meets its burden to demonstrate analytical and procedural reliability;
- 695 d. Non-DOT-compliant tests (e.g., EtG, hair, or forensic novelty panels) shall not be
696 accepted unless:
- 697 (1) The covered individual has provided written informed consent, and
698 (2) The method meets FAA-published reliability thresholds.
- 699 d. Covered individual Expert Review and Equal Evidentiary Weight.
- 700 1. Covered individuals may retain an independent toxicologist, pharmacologist, or
701 laboratory auditor to:
- 702 a. Evaluate test validity and chain of custody;
- 703 b. Identify possible contamination, handling error, or test misuse;
- 704 c. Submit written findings into the FAA record with equal evidentiary weight to
705 FAA or contractor assessments.
- 706 e. Remedies for Disproven or Erroneous Results.
- 707 1. If confirmatory or DNA testing invalidates a positive result:
- 708 a. The covered individual shall be immediately reinstated to full medical and
709 employment status;
- 710 b. All FAA records, internal flags, and summaries referencing the event shall be
711 fully expunged;
- 712 c. The covered individual shall receive compensation for:
- 713 (1) Lost wages, seniority, or duty time,
714 (2) Legal, retesting, or travel expenses,
715 (3) Monitoring costs linked to the error.
- 716 f. Limitations on Redundant or Burdensome Retesting.

- 717 1. No covered individual shall be required to undergo more than one confirmatory test
718 or DNA verification to rebut a positive result;
- 719 2. Additional testing may only be ordered if:
720 a. The original confirmatory result was inconclusive due to lab error; or
721 b. New evidence arises indicating chain-of-custody compromise;
- 722 3. All further testing requests must:
723 a. Be documented in writing,
724 b. Include clinical justification, and
725 c. Be approved by the IMRB.
- 726 g. Oversight, Reporting, and Laboratory Accountability.
- 727 1. The FAA shall publish an Annual Toxicology Oversight Report including:
728 a. Total number of positive test results,
729 b. Number overturned through confirmatory testing or appeal,
730 c. Number linked to lab or procedural error;
- 731 2. Any confirmed error shall trigger a mandatory FAA review of the involved
732 laboratory, collection agency, or vendor;
- 733 3. IAMOC shall receive findings and may recommend decertification, sanction, or
734 public censure;
- 735 4. Repeat offenders may be barred from FAA referrals or reporting for no less than five
736 years.
- 737 h. Restrictions on Premature Reporting by FAA Contractors or Designees.
- 738 1. A HIMS AME, monitoring agency, or FAA-authorized contractor shall not report a
739 positive test result to the FAA, employer, union, or third party unless and until:
740 a. Confirmatory testing is completed;
741 b. The result is scientifically validated and meets chain-of-custody standards;
- 742 2. If a positive result is disproven:
743 a. It shall not be reported under any circumstance;
744 b. No record, note, case summary, or informal communication shall reference the
745 event;
- 746 3. Premature or disproven reporting shall constitute a violation of this Act and expose
747 the individual or entity to:
748 a. Immediate referral suspension;
749 b. Inclusion in the IAMOC Sanctions Registry;

- 750 c. Civil liability under Section 702, including for retaliation, defamation, or
751 reputational harm;
- 752 d. Financial responsibility for the covered individual's legal, occupational, or
753 certification-related losses.
- 754 i. FAA Burden of Proof.
- 755 1. In any disputed test result or adverse action arising therefrom, the burden of proof
756 shall rest exclusively with the FAA to demonstrate:
- 757 a. Sample validity, integrity, and traceability;
- 758 b. Laboratory compliance with FAA toxicology standards;
- 759 c. That any action taken was based on scientific certainty, not presumption,
760 suspicion, or procedural shortcuts.
- 761 j. Totality of Circumstances Before Enforcement Action.
- 762 1. The Federal Aviation Administration (FAA), its contractors, designees, or any
763 affiliated monitoring program shall not initiate adverse medical certification or
764 employment-related action based solely on a single positive, non-negative, or
765 presumptive substance screen unless the following conditions are met:
- 766 a. The FAA has conducted a documented review of the totality of circumstances,
767 including but not limited to:
- 768 (1) The individual's complete testing history;
- 769 (2) Any evidence of recent or ongoing impairment;
- 770 (3) The timing and context of the test in question;
- 771 (4) Results of prior confirmatory or independent tests, if available;
- 772 (5) Any relevant medical or toxicological opinions submitted by the airman.
- 773 b. The airman has been provided the opportunity to:
- 774 (1) Submit an independent toxicological or medical opinion challenging the
775 result;
- 776 (2) Request and obtain confirmatory testing using scientifically valid methods,
777 which may include:
- 778 (a) Gas chromatography/mass spectrometry (GC/MS);
- 779 (b) DNA verification or molecular fingerprinting of the sample;
- 780 (c) Pharmacokinetic or metabolite-specific analysis;

- 781 (d) Any other forensic toxicology method recognized as valid by FAA-
782 published standards or by the Independent Medical Review Board
783 (IMRB).
- 784 (e) Application of evidence-based threshold levels for known sensitive
785 markers such as ethyl glucuronide (EtG), with a threshold not less than
786 500 ng/mL to account for incidental exposure from non-consumptive
787 sources, including personal hygiene products, disinfectants, or
788 occupational solvents.
- 789 c. The FAA has issued a written determination explaining its decision to proceed
790 with enforcement, which shall:
- 791 (1) Cite the scientific and clinical evidence relied upon;
792 (2) Acknowledge and evaluate all evidence submitted by the airman;
793 (3) Affirm that the result is not reasonably attributable to passive exposure,
794 laboratory error, sample contamination, or other benign explanation;
795 (4) Certify that the totality of circumstances was considered in accordance with
796 this subsection.
- 797 2. Any enforcement action taken in the absence of compliance with paragraph 1 shall
798 be deemed procedurally invalid and subject to immediate reversal by the
799 Independent Medical Review Board (IMRB) under Section 202.

800 **SEC. 404. PROHIBITION ON COERCIVE REHABILITATION.**

- 801 a. No covered individual shall be required to enter or remain in any treatment program
802 unless:
- 803 1. There is a clinical diagnosis meeting DSM-5-TR criteria; and
804 2. The covered individual has been offered the opportunity to seek a second opinion.
- 805 b. Inpatient treatment may only be required when there is imminent risk of harm to self or
806 others.
- 807 c. Retaliatory referrals or continued monitoring based on complaints, advocacy, or
808 whistleblowing are expressly prohibited.
- 809 d. Only licensed, evidence-based, non-conflicted providers may receive FAA referrals.
- 810 e. The FAA shall reimburse covered individuals for excessive out-of-state travel, extended
811 housing costs, or lost income caused by unjustified treatment mandates, if no local
812 option was provided.

813 **SEC. 405. FINANCIAL HARDSHIP AND ECONOMIC PROTECTIONS.**

- 814 a. Covered individuals may not be financially burdened with testing, treatment, or
815 evaluation expenses unless:
- 816 1. Requirements are individually justified and documented;
 - 817 2. Costs are disclosed in writing in advance; and
 - 818 3. Financial aid options are provided.
- 819 b. The FAA shall administer a hardship reimbursement fund, available to any covered
820 individual earning less than 400% of the federal poverty line.
- 821 c. Reimbursable expenses may include:
- 822 1. Monitoring costs;
 - 823 2. Treatment travel/lodging;
 - 824 3. Required evaluations; and
 - 825 4. Legal or expert advocacy services related to certification disputes.
- 826 d. Any covered individual wrongfully delayed, revoked, or grounded shall be entitled to:
- 827 1. Immediate reinstatement;
 - 828 2. Full backpay with interest; and
 - 829 3. Record correction with both the FAA and their employer.

830 **SEC. 406. PROTECTION FROM DISCRIMINATION AND BLACKLISTING.**

- 831 a. Employers, unions, and the FAA may not discriminate based on:
- 832 1. Mental health diagnosis or history;
 - 833 2. Substance use history; or
 - 834 3. Participation in monitoring or advocacy.
- 835 b. The FAA shall prohibit:
- 836 1. Off-record communication about past monitoring;
 - 837 2. Coded notes or flags indicating “watch” or “risk” status; and
 - 838 3. Sharing of health data outside the scope of certification itself.
- 839 c. Violations shall constitute civil rights violations under this Act and under applicable
840 federal disability law, including the Americans with Disabilities Act (ADA) and the
841 Rehabilitation Act of 1973.

842 **SEC. 407. EXPEDITED REINSTATEMENT AFTER CLEARANCE.**

- 843 a. Once the FAA restores full certification, a covered individual shall be reinstated by their
844 employer within:
- 845 1. 7 days of covered individual request; or
 - 846 2. 14 days of FAA approval, whichever is later.
- 847 b. Employers must:
- 848 1. Restore previous bid position;
 - 849 2. Maintain seniority and retirement eligibility; and
 - 850 3. Provide any training or simulator sessions without penalty.

851 **SEC. 408. MANDATORY INFORMED CONSENT AND DISCLOSURE.**

- 852 a. FAA-mandated testing, monitoring, or treatment must be authorized in writing by the
853 covered individual, including:
- 854 1. Purpose of the mandate,
 - 855 2. Provider or vendor identity,
 - 856 3. Data use, duration, and revocation terms.
- 857 b. The covered individual must have access to a plain-language explanation of their rights
858 before signing any compliance or consent form.
- 859 c. The FAA shall not share personal health data with any third party, including airlines,
860 contractors, or unions, without signed, specific consent from the covered individual.

861 **SEC. 409. REQUIRED RIGHTS NOTIFICATION AND ACCESS TO BILL OF RIGHTS.**

- 862 a. Upon initiating any certification action, including deferral, denial, or monitoring
863 requirement, the FAA must provide the airman with a written copy of:
- 864 1. This Act's Covered individuals Bill of Rights (Appendix A),
 - 865 2. A clear explanation of what rights apply in their case, and
 - 866 3. Instructions on how to file a challenge, seek independent review, or request
867 reimbursement.
- 868 b. Failure to provide such notice shall suspend any FAA-imposed requirement until the
869 notice is properly delivered, and acknowledged.
- 870 c. No covered individual shall be penalized for exercising their rights under this section,
871 including requesting clarification or seeking counsel before signing any form.

872 **SEC. 410. PROTECTIONS AGAINST UNION COMPLICITY AND FAILURE TO ADVOCATE.**

- 873 a. Prohibition on Compelled Participation or Endorsement by Union Representatives.
- 874 1. No labor union, union-affiliated monitoring representative, or employee assistance
875 professional shall compel or pressure a covered individual to enroll in the HIMS
876 Program, the AEROPath Program, or any FAA-recognized medical monitoring or
877 recovery protocol without first providing:
- 878 a. A written notice of the covered individual's rights under this Act,
879 b. A neutral medical evaluation by a provider unaffiliated with the union or airline,
880 and
881 c. A clear statement that participation is voluntary unless required under a formal
882 FAA determination of disqualification.
- 883 b. Prohibition on Union Interference in Medical Certification.
- 884 1. Labor unions shall not serve as intermediaries, gatekeepers, or enforcers in the FAA
885 medical certification process, including under the AEROPath Program or any
886 successor system. No union may withhold support, deny representation, or
887 condition assistance on participation in a monitoring program.
- 888 c. Mandatory Disclosure of Union Conflicts of Interest.
- 889 1. Any union-affiliated representative advising covered individuals on FAA medical
890 matters must disclose in writing:
- 891 a. Any training, sponsorship, or endorsement received through FAA-affiliated
892 monitoring programs,
893 b. Any financial or contractual relationships with third-party evaluators,
894 monitoring facilities, or advisory bodies.
- 895 d. Duty to Advocate and Represent.
- 896 1. Labor unions have an affirmative duty to advocate for the rights and due process of
897 their members, including the right to challenge inappropriate referrals, overbroad
898 monitoring conditions, and disputed diagnoses. Blind deference to any FAA-
899 endorsed monitoring program shall constitute a breach of the union's duty of fair
900 representation.
- 901 e. Covered individual Right to Independent Advocacy.
- 902 1. Covered individuals shall have the right to seek independent medical, legal, or
903 advocacy counsel of their choosing, and no union or affiliated representative may
904 interfere with or discourage this right. Covered individuals shall not face retaliation,
905 exclusion, or loss of union support for pursuing such independent guidance.

- 906 f. Whistleblower Protection Within Unions.
- 907 1. No union shall retaliate against any member or representative who raises concerns
- 908 about the fairness, transparency, or abuse of the HIMS Program, the AEROPath
- 909 Program, or any FAA-affiliated monitoring system. Protected activities shall include
- 910 internal advocacy, complaints to external authorities, and participation in public
- 911 reform efforts.
- 912 g. Prohibition on Dual Roles.
- 913 1. No individual may serve simultaneously in a union advocacy role and as a
- 914 designated monitor, evaluator, or liaison for any FAA-affiliated recovery or
- 915 monitoring program. This includes roles within the HIMS Program, AEROPath, or
- 916 any successor system. Such dual service constitutes a conflict of interest and
- 917 undermines the covered individual's right to fair representation.
- 918 h. Right to Decline Union-Sponsored Peer Participation.
- 919 1. No covered individual shall be required to work with, report to, or consult with a
- 920 union-appointed peer representative or HIMS liaison as a condition of FAA medical
- 921 certification or airline employment. Covered individuals shall have the right to opt
- 922 out of union-sponsored peer involvement and request independent alternatives
- 923 without penalty or prejudice.
- 924 i. Right to Audit Union Conduct.
- 925 1. Any covered individual affected by a union's actions or inaction related to medical
- 926 certification, HIMS, or AEROPath participation shall have the right to request an
- 927 internal union audit or external arbitration regarding the union's conduct. This
- 928 includes the right to legal redress if the union is found to have breached its duty of
- 929 fair representation.

930 **SEC. 411. CODE OF ETHICS FOR AEROMEDICAL PHYSICIANS HANDLING COVERED**

931 **INDIVIDUAL CASES.**

- 932 a. Establishment. Not later than 180 days after the enactment of this Act, the Federal Air
- 933 Surgeon shall establish and publish a binding Code of Ethics for Aeromedical Physicians,
- 934 including but not limited to Aviation Medical Examiners (AMEs), HIMS-certified AMEs,
- 935 psychiatrists, addiction medicine specialists, neuropsychologists, and any other medical
- 936 professionals who evaluate or report on covered individuals as part of the FAA medical
- 937 certification process.

- 938 b. Required Standards. The Code of Ethics shall, at a minimum, include the following
939 principles:
- 940 1. Fiduciary Responsibility. An aeromedical physician shall place the welfare and
941 rights of the covered individual-patient above institutional, contractual, or political
942 interests.
 - 943 2. Informed Consent and Transparency. All medical evaluations must be conducted
944 with full informed consent, including a clear explanation of scope, purpose, and
945 potential consequences of the evaluation.
 - 946 3. Evidence-Based Practice. No diagnosis, treatment recommendation, or medical
947 deferral shall be made absent clinically valid, peer-reviewed medical evidence.
948 Coercive or blanket practices are prohibited.
 - 949 4. Impartiality and Independence. Physicians shall act independently of employer,
950 union, or FAA pressure. All opinions must reflect honest, individualized medical
951 judgment.
 - 952 5. Duty to Report Misuse. Physicians must report any misuse or abuse of the FAA
953 medical certification process, including retaliation, fabrication, or politically
954 motivated referrals, to the FAA Office of Medical Integrity.
 - 955 6. Confidentiality and Due Process. Covered individual medical information must
956 remain confidential and may not be used or disclosed without proper consent or
957 legal authority. No covered individual shall be reported to the FAA based on
958 suspicion alone.
 - 959 7. Non-Discrimination. Physicians shall not discriminate based on race, religion,
960 gender, personal belief, political affiliation, or participation in advocacy. A covered
961 individual's spiritual stance or philosophy may not be used as a basis for denying
962 certification.
 - 963 8. Right to Second Opinions. Covered individuals have the right to seek a second
964 opinion or independent review at their own expense, and such efforts shall not be
965 viewed as noncompliance.
 - 966 9. Mandatory Report Disclosure. Any report, letter, or clinical summary submitted by a
967 physician to the FAA regarding a covered individual shall also be provided in full to
968 the covered individual, at the time it is submitted, and at no additional cost. This
969 requirement applies regardless of whether the report was ordered by the FAA, the

970 employer, or initiated independently. Failure to provide the report to the covered
971 individual shall be grounds for professional sanction under this section.

972 c. Enforcement.

973 1. Violations of this Code of Ethics may result in removal from FAA medical programs,
974 revocation of designation status, referral to state licensing boards, and permanent
975 exclusion from participation in any FAA covered individual certification evaluations.

976 2. Covered individuals may file complaints with the FAA Office of Medical Integrity,
977 which shall acknowledge within 15 days and resolve within 60 days, with findings
978 and actions disclosed to the covered individual in writing.

979 d. Publication and Training. The FAA shall publish this Code publicly and require all
980 participating physicians to complete annual training and sign an attestation of
981 compliance as a condition of designation.

982 e. Additional Ethical Safeguards.

983 1. Prohibition on Retaliation. Physicians shall not retaliate, directly or indirectly,
984 against a covered individual for exercising their rights, requesting a second opinion,
985 filing a complaint, or questioning medical recommendations. Any act of retaliation is
986 grounds for immediate decertification.

987 2. Conflict of Interest Declarations. All aeromedical physicians must disclose any
988 potential conflicts of interest, including financial ties to monitoring facilities,
989 evaluators, or treatment centers. Failure to disclose shall constitute a breach of this
990 Code.

991 3. Prohibition on Third-Party Ghostwriting or Unreviewed Edits. No report, opinion, or
992 evaluation may be edited, summarized, or supplemented by third parties without
993 the explicit review and written consent of the originating physician. Ghostwriting or
994 unauthorized editing shall be treated as misconduct.

995 4. Sanctions Framework for Violations. Violations of this Code shall be subject to a
996 three-tiered sanction system, including (1) warning and retraining; (2) removal
997 from FAA designation panels; and (3) referral to state licensing authorities for
998 investigation and possible suspension or revocation.

999 5. Covered individual Right to Review and Rebut Reports. Covered individuals shall
1000 have the right to review and formally rebut any factual errors in medical reports
1001 submitted to the FAA. Physicians must allow a rebuttal submission prior to or
1002 alongside final report transmission.

- 1003 6. Ban on Vague or Subjective Evaluations. All evaluations must be based on clear,
1004 objective criteria. Vague, unexplained, or subjective language (e.g., “guarded,”
1005 “watchful waiting,” or “spiritual resistance”) must be accompanied by specific
1006 supporting evidence and clinical rationale.
- 1007 7. Required Use of DSM Diagnostic Criteria. Any diagnosis rendered by a physician
1008 must meet full DSM-5-TR criteria. Partial, implied, or informal labels shall not be
1009 accepted for certification purposes.
- 1010 8. Protection Against Religious or Philosophical Judgment. A physician shall not
1011 question, penalize, or cite a covered individual's religious beliefs, atheism, or refusal
1012 to adopt a 12-step framework as evidence of noncompliance, poor prognosis, or
1013 risk.

1014 **SEC. 412. MANDATED INSURANCE COVERAGE FOR FAA-MEDICAL REQUIREMENTS.**

- 1015 a. Purpose.
- 1016 1. This section is intended to prevent undue financial hardship for airmen required to
1017 comply with FAA medical certification requirements.
- 1018 2. Specifically, it ensures that health insurance policies cover all FAA-mandated
1019 services necessary for medical certification, recognizing such services as essential to
1020 the airman’s livelihood.
- 1021 b. Coverage Mandate.
- 1022 1. Any health insurance plan regulated under Federal or State law that provides
1023 coverage for mental health, behavioral health, substance use disorder treatment, or
1024 general medical services shall—
- 1025 a. include full coverage for any medical service, test, or evaluation that is—
- 1026 (1) expressly required or directed by the FAA or an FAA-designated medical
1027 officer; and
- 1028 (2) necessary to obtain, retain, or restore a medical certificate under 14 C.F.R.
1029 Part 67.
- 1030 b. recognize FAA-directed services as medically necessary without requiring
1031 further clinical justification beyond the FAA directive.
- 1032 c. Covered Services.
- 1033 1. Services required to be covered under subsection b. shall include, but are not
1034 limited to—

- 1035 a. substance use or psychiatric evaluations;
- 1036 b. neuropsychological or cognitive testing;
- 1037 c. therapy or counseling, including group or individual sessions;
- 1038 d. monitoring or compliance programs, including HIMS or AEROPath protocols;
- 1039 e. drug or alcohol testing required under a Special Issuance or FAA monitoring
- 1040 protocol;
- 1041 f. follow-up visits, lab testing, documentation, or review sessions required to
- 1042 support FAA medical certification.
- 1043 d. Parity and Non-Discrimination.
- 1044 1. Insurance carriers shall not—
- 1045 a. impose higher deductibles, copayments, preauthorization requirements, or
- 1046 documentation burdens on FAA-mandated services than for equivalent non-aviation
- 1047 medical services;
- 1048 b. deny coverage for FAA-required services on the grounds that the services are
- 1049 occupational, certification-related, or nontraditional.
- 1050 2. All FAA-required services shall be treated as medically necessary under the plan and
- 1051 reimbursed accordingly.
- 1052 e. Coordination with Public Assistance.
- 1053 1. In the event that an airman is eligible for financial support under Section 405 or
- 1054 Section 711—
- 1055 a. private insurance shall serve as the primary payer;
- 1056 b. public funds may serve as a secondary payer to offset:
- 1057 (1) uncovered services;
- 1058 (2) excessive copayments or deductibles exceeding 20 percent of the total cost;
- 1059 or
- 1060 (3) services required during coverage gaps or when the airman is uninsured.
- 1061 2. Nothing in this section shall limit an airman's right to access other federal aid
- 1062 authorized by this Act.
- 1063 f. Implementation and Oversight.
- 1064 1. The Secretary of Transportation and the Secretary of Health and Human Services
- 1065 shall—
- 1066 a. issue implementing regulations within 12 months of enactment;
- 1067 b. create a reporting mechanism for airmen to challenge coverage denials for FAA-

- 1068 required services; and
- 1069 c. refer any recurring violations to State insurance regulators for enforcement.
- 1070 2. State insurance commissioners shall have full enforcement authority over policies
- 1071 regulated under their jurisdiction.
- 1072 g. Rule of Construction.
- 1073 1. Nothing in this section shall—
- 1074 a. require airmen to submit to services not otherwise required by the FAA;
- 1075 b. be construed as an endorsement of any specific provider, treatment model, or
- 1076 recovery program; or
- 1077 c. limit the airman’s rights to appeal or challenge FAA medical requirements
- 1078 under other sections of this Act.

1079 **SEC. 413. PROHIBITION ON LIFE INSURANCE DISCRIMINATION BASED ON SUBSTANCE**

1080 **USE DISORDER DIAGNOSIS**

- 1081 a. Congressional Findings.
- 1082 1. Substance Use Disorder (SUD) is a recognized and treatable medical condition,
- 1083 not a moral failing.
- 1084 2. Thousands of covered individuals across aviation have demonstrated long-term
- 1085 recovery and medical stability following treatment.
- 1086 3. Life insurance underwriting decisions that deny or restrict coverage solely due
- 1087 to a past SUD diagnosis—regardless of remission status—are inconsistent with
- 1088 scientific evidence, recovery outcomes, and the principles of disability non-
- 1089 discrimination.
- 1090 4. These practices impose economic harm, deter transparency, and discourage
- 1091 individuals from seeking treatment or disclosing mental health struggles.
- 1092 5. Congressional action is necessary to ensure that airmen and other aviation
- 1093 professionals are not penalized for a medical history that is no longer indicative
- 1094 of current risk.
- 1095 6. This section is consistent with the intent of the Mental Health Parity and
- 1096 Addiction Equity Act of 2008, the Americans with Disabilities Act, and the
- 1097 Rehabilitation Act of 1973, which prohibit discrimination on the basis of
- 1098 disability or mental health condition.
- 1099 b. Nondiscrimination Requirements.

- 1100 1. No life insurance carrier doing business in the United States may deny, delay,
1101 restrict, underwrite, or rate any life insurance policy based solely on:
- 1102 a. A current or historical diagnosis of Substance Use Disorder (SUD);
1103 b. Participation in a treatment, monitoring, or FAA-mandated recovery
1104 program; or
1105 c. A Special Issuance or administrative designation applied in the absence
1106 of a current disqualifying medical condition.
- 1107 2. Underwriting decisions must be based on current clinical evidence and
1108 individualized risk, not on historical diagnosis or administrative label alone.
- 1109 3. No underwriting model, algorithm, or artificial intelligence system may
1110 incorporate historical SUD diagnosis or treatment participation as a proxy
1111 variable or risk multiplier, unless current clinical impairment is also present and
1112 documented.
- 1113 c. Allowable Risk Considerations.
- 1114 1. Insurers may consider the following risk factors in life insurance underwriting,
1115 provided they are supported by documentation:
- 1116 a. Active substance use or impairment within the preceding 12 months;
1117 b. Current legal supervision or court-ordered treatment related to
1118 substance use; or
1119 c. A current diagnosis of uncontrolled or untreated Substance Use
1120 Disorder.
- 1121 2. The presence of one or more of these factors must be verified by current
1122 medical or legal records before being used to justify adverse action.
- 1123 3. If an application is denied, delayed, or rated based in whole or in part on a
1124 medical factor, the applicant shall receive a written explanation including the
1125 specific factor(s) considered and a plain-language description of how it
1126 impacted underwriting.
- 1127 d. Presumption of Remission.
- 1128 1. An applicant shall be presumed to be in sustained remission if they have:
- 1129 a. Successfully completed a recognized treatment or monitoring program;
1130 and
1131 b. Remained free from relapse, re-treatment, or substance-related legal
1132 incidents for a period of two (2) or more consecutive years.

- 1133 2. No adverse underwriting decision may be made solely on the basis of a past
1134 diagnosis for individuals who meet this remission standard.
- 1135 e. Enforcement and Remedies.
- 1136 1. This section shall be enforced by the Independent Aeromedical Oversight
1137 Council (IAMOC), in coordination with state insurance regulators and relevant
1138 federal consumer protection agencies.
- 1139 2. Violations shall constitute unlawful discrimination and may result in:
- 1140 a. Civil penalties;
- 1141 b. Public sanction; and
- 1142 c. Referral to the Department of Transportation or state insurance
1143 commissioners for regulatory enforcement.
- 1144 3. Affected individuals may submit a formal complaint through a binding
1145 administrative remedy process to be established under this Act.
- 1146 4. For purposes of this section, the term “life insurance carrier” includes any entity
1147 engaged in the underwriting, sale, pricing, administration, or reinsurance of life
1148 insurance products in the United States, whether directly or through affiliates.
- 1149 5. No insurer shall take retaliatory action against any applicant who files a
1150 complaint, appeal, or seeks legal redress under this section.

1151 **SEC. 414. TRANSPARENCY AND FREEDOM IN EVALUATOR ACCESS**

- 1152 a. Public Accessibility of Evaluator Listings.
- 1153 1. The FAA shall maintain and publish a publicly accessible online directory of all
1154 professionals currently designated or approved to conduct medical evaluations
1155 related to substance use, psychiatric, neuropsychological, or behavioral
1156 conditions under the HIMS or AEROPath framework. This shall include:
- 1157 a. HIMS-certified Aviation Medical Examiners (AMEs);
- 1158 b. FAA-accepted psychiatrists; and
- 1159 c. FAA-accepted neuropsychologists.
- 1160 2. The directory shall include, at minimum:
- 1161 a. Full name and professional credentials;
- 1162 b. State(s) of licensure and practice location(s);
- 1163 c. Medical or clinical specialties;

- 1164 d. Years of designation (if applicable) and number of FAA referrals
1165 accepted in the previous calendar year;
1166 e. Contact method or referral procedure;
1167 f. Whether the evaluator is currently accepting new FAA referrals.
- 1168 3. The FAA shall update the directory at least quarterly and shall make it available
1169 to the public online, without requiring submission of a Freedom of Information
1170 Act (FOIA) request.
- 1171 b. Freedom to Select Designated Medical Professionals.
- 1172 1. No covered individual shall be required to use a specific FAA-designated AME,
1173 psychiatrist, neuropsychologist, or other evaluator selected by the FAA, an
1174 airline, a union, or a third-party HIMS administrator.
- 1175 2. All FAA-referred evaluations must honor the covered individual's right to
1176 choose from among any qualified professionals listed in the publicly available
1177 directory established in subsection (a).
- 1178 3. Any FAA or employer attempt to restrict this choice—through coercion, undue
1179 delay, or de facto mandates—shall be considered a violation of this statute.
- 1180 c. Disclosure of Evaluator Relationships.
- 1181 1. All FAA-approved evaluators shall be required to disclose to the FAA and the
1182 covered individual undergoing evaluation:
- 1183 a. Any active or prior employment, consulting, or contractual relationship
1184 with the FAA, air carrier, union, or program management entity;
- 1185 b. Any financial interest or incentives tied to referral volume or placement;
- 1186 c. Any known conflicts of interest relevant to the subject or sponsor of the
1187 evaluation.
- 1188 d. Remedies.
- 1189 1. Any covered individual who believes their right to select an evaluator was
1190 obstructed or denied may petition the Independent Aeromedical Oversight
1191 Council (IAMOC) for review and remedy.
- 1192 2. IAMOC shall investigate and issue corrective action or guidance within 30
1193 calendar days of receiving such a complaint.

1194 **SEC. 415. FAIR ACCESS AND PROTECTIONS FOR FAA-DESIGNATED EVALUATORS.**

- 1195 a. Covered Evaluator Roles.

- 1196 1. This section shall apply to any licensed professional acting in an FAA-recognized
1197 evaluative capacity for medical certification purposes, including but not limited
1198 to:
- 1199 a. HIMS-certified Aviation Medical Examiners (AMEs);
 - 1200 b. Board-certified psychiatrists;
 - 1201 c. Licensed neuropsychologists;
 - 1202 d. Any independent evaluator approved to perform substance use,
1203 cognitive, or psychiatric assessments for FAA certification.
- 1204 b. Equal Access and Eligibility.
- 1205 1. The FAA shall not restrict or limit an evaluator's ability to participate in FAA-
1206 recognized assessments based on:
 - 1207 a. Advocacy for covered individual rights;
 - 1208 b. Clinical conclusions that differ from FAA expectations;
 - 1209 c. Refusal to recommend unnecessary treatment or prolonged monitoring;
 - 1210 d. Lack of affiliation with union-sponsored, airline-referred, or FAA-
1211 preferred evaluator groups.
 - 1212 2. Any evaluator who meets published qualifications shall be eligible to accept
1213 referrals, and no exclusive or secret pool of evaluators may be maintained.
- 1214 c. Protection from Retaliation or Suppression.
- 1215 1. The FAA, its contractors, and its medical designees shall not:
 - 1216 a. Penalize, de-designate, or bypass an evaluator based on noncompliance
1217 with legacy program culture;
 - 1218 b. Use subjective or undocumented criteria to disqualify evaluators;
 - 1219 c. Withhold covered individual reports solely due to evaluator identity.
 - 1220 2. Any adverse action against an evaluator shall be based solely on documented:
 - 1221 a. Clinical misconduct;
 - 1222 b. Violation of published FAA medical policy;
 - 1223 c. Failure to meet objective certification standards.
- 1224 d. Right to Appeal and Due Process.
- 1225 1. Evaluators subject to removal, limitation, or referral exclusion shall have the
1226 right to:
 - 1227 a. Receive a written explanation from the FAA;

- 1228 b. Submit a formal response;
- 1229 c. Appeal the decision to the Independent Aeromedical Oversight Council
- 1230 (IAMOC).
- 1231 2. IAMOC shall investigate within 60 days and may:
 - 1232 a. Order reinstatement;
 - 1233 b. Issue findings of undue suppression;
 - 1234 c. Recommend disciplinary action against FAA officials involved.
- 1235 e. Publication and Transparency.
 - 1236 1. IAMOC shall publish a biennial Evaluator Integrity Report summarizing:
 - 1237 a. All complaints filed under this section;
 - 1238 b. Patterns of evaluator suppression or favoritism;
 - 1239 c. Recommendations to improve fairness and evaluator protections.

1240 **SEC. 416. PATIENT PROTECTION AND TRANSPARENCY.**

- 1241 a. Purpose.
 - 1242 1. The purpose of this section is to ensure that all covered individuals subject to
 - 1243 FAA-mandated, employer-mandated, peer-program, union-recommended, or
 - 1244 otherwise compelled aeromedical evaluations are afforded transparency,
 - 1245 fairness, and protection from misconduct, coercion, and abuse by Aviation
 - 1246 Medical Examiners (AMEs), psychiatrists, psychologists, neuropsychologists, or
 - 1247 other evaluators.
- 1248 b. Applicability.
 - 1249 1. For purposes of this section, any evaluation, test, or treatment recommendation
 - 1250 conducted under threat—explicit or implicit—of adverse FAA action, certificate
 - 1251 suspension, or employment consequence shall be deemed mandatory and
 - 1252 covered under this section, regardless of whether participation is labeled
 - 1253 voluntary.
- 1254 c. Mandatory Recording of Sessions.
 - 1255 1. All covered evaluations shall be fully and contemporaneously audio recorded;
 - 1256 video recording shall be permitted where clinically feasible to capture
 - 1257 demeanor and context.
 - 1258 2. A complete copy of the recording shall be provided to the covered individual at
 - 1259 no cost within seven (7) calendar days.

- 1260 3. Covered individuals shall have the right to make their own independent audio or
1261 video recordings without prior notice or permission, and such recordings shall
1262 be lawful and admissible for all administrative and legal purposes.
- 1263 4. Recordings shall be retained for not less than seven (7) years and stored
1264 securely with auditable chain-of-custody.
- 1265 5. An independent repository designated by IAMOC shall maintain the official
1266 master copy of all recordings and reports.
- 1267 6. Tampering with, altering, or destroying recordings shall constitute a
1268 sanctionable violation under Title VII.
- 1269 7. Any FAA or employer action based on a noncompliant evaluation shall be
1270 deemed procedurally invalid and vacated until a compliant evaluation is
1271 completed.
- 1272 d. Evaluator Accountability.
- 1273 1. Evaluators must cite full DSM-5-TR or ICD criteria for any diagnosis and provide
1274 a written, evidence-based clinical rationale.
- 1275 2. Evaluator reports must be transmitted simultaneously to the covered individual,
1276 IAMOC, and the FAA.
- 1277 3. Any evaluator who submits a materially false, misleading, or clinically
1278 unsupported report, or who significantly deviates from accepted standards of
1279 care, shall be subject to mandatory IAMOC investigation and, if confirmed,
1280 removal from FAA-approved panels.
- 1281 4. IAMOC shall maintain a public list of evaluators removed or sanctioned under
1282 this subsection.
- 1283 e. Independent Oversight Review.
- 1284 1. Covered individuals may submit recordings, documentation, and rebuttal
1285 statements to IAMOC before any adverse FAA or employer action is taken.
- 1286 2. IAMOC shall have authority to compel evaluator cooperation, require document
1287 production, and take testimony under oath.
- 1288 3. IAMOC shall issue findings within thirty (30) calendar days unless extended for
1289 good cause.
- 1290 4. Findings of IAMOC shall be binding on the FAA and any employer, including the
1291 authority to vacate actions, modify monitoring terms, or order reinstatement.

- 1292 5. No individual shall be subjected to more than one evaluation per specialty
1293 within a twelve (12)-month period absent new evidence or IAMOC approval for
1294 good cause.
- 1295 6. IAMOC shall publish a biennial Patient Protection Report summarizing the
1296 number of complaints, outcomes, sanctions, and recommendations for systemic
1297 improvement.
- 1298 f. AME and Evaluator Transparency.
- 1299 1. Evaluators must disclose all conflicts of interest, including financial, contractual,
1300 or institutional relationships with airlines, unions, insurers, or program
1301 administrators.
- 1302 2. Evaluators must provide itemized cost estimates before services are rendered
1303 and submit to IAMOC-mediated fee review upon dispute.
- 1304 3. Covered individuals may request reassignment to a different evaluator or AME if
1305 bias, conflict, or misconduct is reasonably suspected, without penalty or delay.
- 1306 g. Protection from Interference and Intimidation.
- 1307 1. Covered individuals may not be subjected to intimidation, coaching, or presence
1308 of employer representatives during evaluations unless the individual consents
1309 in writing. Any violation shall constitute coercion under this Act.
- 1310 h. Protection from Retaliation.
- 1311 1. No adverse action, punitive monitoring, denial of advancement, or employment
1312 consequence may be imposed solely for exercising rights under this section.
- 1313 2. Violations shall be subject to the remedies in Section 708, including
1314 reinstatement, back pay, damages, and mandatory investigation, with the
1315 burden on the FAA or employer to prove that actions were unrelated to
1316 protected conduct.
- 1317 i. Coverage for Telehealth and Technology.
- 1318 1. All protections under this section apply equally to in-person, telehealth, or
1319 remote evaluations.
- 1320 2. Any use of algorithmic, AI-assisted, or automated decision tools must be
1321 disclosed in writing and be subject to IAMOC audit for bias, validity, and
1322 compliance with clinical standards.
- 1323 3. FAA shall periodically update regulations to ensure alignment with emerging
1324 technologies and best practices.

1325 **TITLE V — IMPLEMENTATION AND OVERSIGHT**

1326 **SEC. 501. COVERED INDIVIDUAL MEDICAL DATA RIGHTS AND PRIVACY**
1327 **PROTECTIONS.**

- 1328 a. Covered individuals shall have full access to their FAA medical certification file,
1329 including:
- 1330 1. All correspondence, case notes, and documentation,
 - 1331 2. Internal FAA communications and memoranda,
 - 1332 3. Reports from contractors, AMEs, or third parties relied upon by the FAA.
- 1333 b. Covered individuals may request corrections or removal of inaccurate, outdated, or
1334 misleading entries.
- 1335 c. The FAA may not share or disclose any portion of the covered individual’s medical file
1336 — including narrative summaries — without signed, specific, revocable consent.
- 1337 d. The FAA shall develop and maintain a secure online portal that provides real-time
1338 access to:
- 1339 1. Case status,
 - 1340 2. Upcoming deadlines,
 - 1341 3. Required documentation,
 - 1342 4. Communications from FAA medical staff or contractors.
- 1343 e. The portal must include:
- 1344 1. Upload functionality for covered individual-submitted documents,
 - 1345 2. Timestamped log of FAA actions and communications,
 - 1346 3. Immediate notification to covered individuals of any file changes or new actions.
- 1347 f. Failure to update the portal within 7 days of action shall constitute procedural failure
1348 and may entitle the covered individual to:
- 1349 1. Expedited review,
 - 1350 2. Tolling of all deadlines until corrected, and
 - 1351 3. Statutory damages up to \$25,000 per incident if harm results.

1352 **SEC. 502. OVERSIGHT BY THE DEPARTMENT OF TRANSPORTATION INSPECTOR**
1353 **GENERAL.**

- 1354 a. Within 12 months of enactment, the DOT Inspector General (DOT OIG) shall conduct a
1355 full audit of FAA aeromedical practices, including:
- 1356 1. Average certification decision timeframes,

- 1357 2. Patterns of deferral and denial by diagnosis,
1358 3. Cost burdens imposed on covered individuals,
1359 4. Retaliatory or coercive practices, and
1360 5. Use of undisclosed documentation or unreviewable “flags.”
- 1361 b. The OIG shall produce a public report and submit findings to:
1362 1. The FAA Administrator,
1363 2. Congress (House and Senate Transportation Committees), and
1364 3. The Independent Oversight Council (IAMOC).
- 1365 c. The OIG shall issue follow-up audits every 2 years for the first 6 years post-enactment to
1366 track reform implementation and ongoing compliance.

1367 **SEC. 503. CREATION OF THE INDEPENDENT OVERSIGHT COUNCIL (IAMOC).**

- 1368 a. The Act establishes the Independent Aeromedical Oversight Council (IAMOC) to
1369 monitor FAA compliance and receive covered individual complaints.
- 1370 b. IAMOC shall consist of 7 voting members, selected by independent panels composed of
1371 aviation stakeholders to ensure fairness, diversity of expertise, and integrity across the
1372 aviation community:
- 1373 1. 2 retired aviation community members with firsthand experience under FAA
1374 medical monitoring (e.g., covered individuals, controllers, mechanics)1 clinical
1375 ethicist or patient rights advocate,
1376 2. 1 currently designated HIMS-certified AME with relevant medical background
1377 and training,
1378 3. 1 representative appointed by an independent covered individual reform
1379 organization,
1380 4. 1 clinical ethicist or patient rights advocate,
1381 5. 1 representative from the DOT OIG (non-voting liaison),
1382 6. 1 currently designated HIMS-certified AME, selected through a vote
1383 administered by individuals from the aviation community who have
1384 participated in FAA medical monitoring or certification oversight in the past 10
1385 years. This AME shall:
- 1386 a. Have no financial or institutional ties to unions, carriers, or FAA
1387 contracts for the past three years,
1388 b. Possess a minimum of five years’ direct experience in FAA-related
1389 aeromedical decision-making,

- 1390 c. Serve as a full voting member, subject to public conflict-of-interest
1391 disclosure and reconfirmation every term.
- 1392 7. One voting representative appointed by an independent aviation reform
1393 coalition unaffiliated with regulatory agencies, unions, or employers. This
1394 member shall be confirmed by a panel of aviation stakeholders and serve a
1395 renewable three-year term.
- 1396 c. Initial Appointments
- 1397 1. The Secretary of Transportation shall appoint all IAMOC members within 90
1398 days of enactment.
- 1399 2. IAMOC shall convene its first meeting no later than 120 days post-enactment.
- 1400 3. To preserve independence and avoid conflicts of interest, no individual or
1401 organization with an active contractual, financial, or advisory relationship with
1402 the FAA, a covered individual union, or an air carrier may participate in the
1403 nomination, selection, or appointment of IAMOC members.
- 1404 4. At least fifty percent (50%) of the nominating entities for IAMOC appointments
1405 must be composed of independent covered individual- or controller-led reform
1406 organizations unaffiliated with regulatory, union, or employer structures. These
1407 entities shall represent the aviation community broadly and include
1408 stakeholders from commercial, general aviation, and student covered individual
1409 sectors.
- 1410 d. IAMOC responsibilities include:
- 1411 1. Investigating FAA noncompliance or abuse,
1412 2. Reviewing whistleblower and retaliation claims,
1413 3. Reviewing statistical trends across diagnosis and demographic groups,
1414 4. Making annual recommendations for policy change.
- 1415 e. IAMOC shall publish an Annual Oversight Report made available to the public and
1416 Congress, summarizing:
- 1417 1. FAA compliance status,
1418 2. Key data trends and concerns,
1419 3. Disciplinary or decertification recommendations.
- 1420 f. Covered individual advocacy representation requirement.

- 1421 1. The IAMOC shall include one voting representative appointed by a recognized
1422 independent covered individual advocacy organization unaffiliated with any
1423 union or regulatory body.
- 1424 2. The representative shall be selected by consensus of nationally recognized
1425 covered individual-led reform coalitions and serve a renewable 3-year term.
- 1426 3. This provision ensures that covered individual interests are directly and
1427 independently represented in policy oversight and reform monitoring.

1428 **SEC. 504. SUNSET AND TRANSITION OF LEGACY HIMS PROGRAM.**

- 1429 a. The FAA shall sunset the HIMS Program within 24 months of enactment.
- 1430 b. No new covered individuals shall be enrolled in HIMS after the 24-month mark.
- 1431 c. All current HIMS participants shall receive:
- 1432 1. Written notice of the opportunity to transition to AEROPath,
- 1433 2. A credit for all time served under HIMS,
- 1434 3. Freedom from any penalty or deferral based solely on transfer.
- 1435 d. After 24 months, the FAA may not reference prior HIMS participation as:
- 1436 1. A disqualifying factor,
- 1437 2. A basis for extended monitoring,
- 1438 3. A justification for additional review, delay, or restriction.
- 1439 e. No FAA-affiliated program, protocol, or monitoring system may replicate the structure,
1440 referral mechanisms, conditions, or oversight features of the legacy HIMS Program
1441 under a different name or administrative framework.
- 1442 f. Any future FAA-supported medical oversight system must conform to the standards,
1443 eligibility protections, and independent governance established by this Act and the
1444 AEROPath framework.

1445 **SEC. 505. TRANSITION PRIVACY, CONSENT, AND TESTING PROTECTIONS FOR LEGACY**
1446 **MONITORING PROGRAMS.**

- 1447 a. During the transition period outlined in Section 504, the following safeguards shall
1448 apply to any covered individual currently subject to requirements imposed under the
1449 legacy HIMS Program or any other discontinued FAA monitoring framework:
- 1450 1. Specific consent required.
- 1451 a. The FAA shall not require blanket HIPAA authorizations. All disclosures
1452 of personal health information must be:

- 1453 i Specific in purpose and scope,
1454 ii Time-limited, and
1455 iii Based on clearly defined, case-specific criteria.
- 1456 b. Disclosure of individually identifiable health information shall be
1457 permissible only with case-by-case written consent, and only for
1458 purposes directly related to certification review or safety-related
1459 investigation.
- 1460 2. Clarity in testing requirements.
- 1461 a. All FAA-authorized testing protocols for legacy monitoring participants
1462 must:
- 1463 i Clearly delineate the test type (e.g., DOT, EtG), collection
1464 procedures, and testing frequency;
1465 ii Be disclosed in writing to the covered individual; and
1466 iii Not require covered individuals to submit to non-DOT testing on
1467 days off or outside duty periods unless arranged in advance with
1468 written covered individual consent.
- 1469 3. Protections against unintended disclosure.
- 1470 a. Airlines shall not publicly identify covered individuals as participants in
1471 legacy monitoring or remove them from bid lists without documented
1472 cause.
- 1473 b. All disclosures must be anonymized and shall not reveal any underlying
1474 medical classification.
- 1475 c. The FAA shall issue guidance prohibiting disclosure of any medical
1476 program identifiers (e.g., "HIMS") without express covered individual
1477 consent.
- 1478 4. Standardization of medical certificate format.
- 1479 a. The FAA shall ensure that medical certificates issued under Special
1480 Issuance (SI) authority are visually and structurally identical to non-SI
1481 certificates, such that no distinction can be made by employers, peers, or
1482 third parties based on the certificate's appearance alone.
- 1483 b. No notation, code, or formatting variation may be used to denote SI
1484 status on the face of a medical certificate.

- 1485 c. Verification of SI status shall be accessible only to FAA-authorized
1486 personnel on a need-to-know basis, and not shared with employers
1487 unless specifically required by law or regulation.
- 1488 d. Any existing system that allows external inference of SI status from
1489 certificate formatting shall be revised within 180 days of enactment.
- 1490 5. Retroactive relief clause.
- 1491 a. This section shall apply retroactively to any individual subjected to
1492 HIMS-related medical oversight from January 1, 2016 onward.
- 1493 b. Legal redress, public records requests, or participation in class action
1494 shall not be barred by prior consent or waiver agreements.
- 1495 6. Contractual and anti-discrimination protections.
- 1496 a. No covered individual participating in the transition away from HIMS
1497 shall be subject to:
- 1498 i Employment discrimination based on past program status;
1499 ii Denial of promotion, scheduling, or training opportunities due to
1500 prior monitoring enrollment; or
1501 iii Delays in medical certification or reinstatement based solely on
1502 legacy program participation.

1503 **SEC. 506. PUBLIC TRANSPARENCY AND CERTIFICATION DASHBOARD.**

- 1504 a. Public Dashboard Requirement.
- 1505 1. The FAA shall maintain a public-facing, online dashboard displaying
1506 standardized, aggregate, anonymized data related to all FAA-recognized medical
1507 monitoring programs, including the legacy HIMS Program and the AEROPath
1508 Program.
- 1509 2. The dashboard shall be:
- 1510 a. Searchable and sortable;
1511 b. Downloadable in machine-readable format; and
1512 c. Updated no less than quarterly.
- 1513 b. Mandatory Data Metrics.
- 1514 The dashboard shall, at a minimum, include the following metrics, reported separately
1515 for each program year and disaggregated by: (1) certificate class (first, second, third),
1516 (2) medical certificate type, and (3) employment category (Part 121, Part 135, Part 91,
1517 general aviation, corporate, and military-to-civilian):
- 1518 1. Program Participation
- 1519 a. Total number of participants enrolled;
1520 b. New enrollments by year;

- 1521 c. Geographic distribution of participants by state and FAA region.
- 1522 2. Entry Triggers
- 1523 a. DUI or other alcohol-related offense;
- 1524 b. Employer referral;
- 1525 c. Self-disclosure without incident;
- 1526 d. Accident or incident with suspected impairment;
- 1527 e. Positive test result (specify type);
- 1528 f. Other (with description).
- 1529 3. Monitoring Duration
- 1530 a. Average and median duration in months;
- 1531 b. Duration by trigger type;
- 1532 c. Number and percentage exceeding 36 months.
- 1533 4. Outcomes
- 1534 a. Number graduated from monitoring;
- 1535 b. Number placed in indefinite or extended monitoring;
- 1536 c. Number who lost certification;
- 1537 d. Number who voluntarily withdrew from program;
- 1538 e. Number re-entering program after graduation (with reason codes).
- 1539 5. Medical Diagnosis at Entry
- 1540 a. Alcohol dependence;
- 1541 b. Alcohol abuse;
- 1542 c. No formal diagnosis;
- 1543 d. Other disqualifying conditions.
- 1544 6. Testing Data
- 1545 a. Average and median number of tests per participant per year;
- 1546 b. Total tests administered by type (PEth, EtG/EtS, urine, hair, etc.);
- 1547 c. Pass/fail rates by test type;
- 1548 d. Number and percentage of disputed results;
- 1549 e. False-positive rate with resolution outcomes.
- 1550 7. Appeals and Case Resolution
- 1551 a. Number of appeals filed;
- 1552 b. Appeal outcomes (granted, denied, modified);
- 1553 c. Average time to resolution for certification cases.
- 1554 8. Cost Data
- 1555 a. Average, median, and range of total participant costs;
- 1556 b. Breakdown of costs (evaluations, testing, travel, treatment).
- 1557 9. Provider and Evaluator Data
- 1558 a. Number of active HIMS AMEs, psychiatrists, and neuropsychologists
- 1559 handling cases;
- 1560 b. Average case load per provider type;
- 1561 c. Median and range of time-to-appointment by provider type;
- 1562 d. Provider-specific appeal/reversal rates (in aggregate, anonymized
- 1563 form).

- 1564 10. Geographic & Access Equity
- 1565 a. Wait times for required evaluations by FAA region;
- 1566 b. Travel distances required for testing or evaluation appointments;
- 1567 c. Number and percentage of participants required to travel out-of-state
- 1568 for mandated services.
- 1569 11. Safety and Incident Tracking
- 1570 a. Number of participants involved in incidents or accidents during
- 1571 monitoring (categorized by cause and outcome);
- 1572 b. Number of incidents leading to program re-entry after graduation.
- 1573 12. Step-Down and Early Release Data
- 1574 a. Number and percentage of participants approved for early release
- 1575 before maximum duration;
- 1576 b. Average time to step-down approval after meeting eligibility criteria.
- 1577 13. Monitoring Methodology
- 1578 a. Percentage of participants required to attend 12-step vs. alternative
- 1579 programs;
- 1580 b. Frequency and type of mandated peer or sponsor meetings;
- 1581 c. Use of remote vs. in-person check-ins.
- 1582 14. Compliance Actions
- 1583 a. Number of participants cited for noncompliance by category (missed
- 1584 test, late paperwork, etc.);
- 1585 b. Resolution outcomes for noncompliance actions (warning, extended
- 1586 monitoring, revocation, etc.).
- 1587 15. Testing Logistics
- 1588 a. Average notice time for random tests;
- 1589 b. Number and percentage of tests conducted outside a participant's home
- 1590 state;
- 1591 c. Percentage of tests conducted on declared unavailable days that were
- 1592 later overturned.
- 1593 16. Data Integrity & Audit Results
- 1594 a. Annual FAA audit findings on accuracy of HIMS data reporting;
- 1595 b. Number of confirmed data errors or omissions discovered in audits;
- 1596 c. Corrective actions taken in response to data integrity issues.
- 1597 c. Independent Oversight Review.
- 1598 The Independent Aviation Medical Oversight Council (IAMOC) shall review the
- 1599 completeness, accuracy, and integrity of all reported metrics annually and may require
- 1600 the FAA to collect and publish additional data necessary for program evaluation and
- 1601 improvement.
- 1602 d. Non-Discretionary Obligation.
- 1603 The FAA shall have no discretion to omit any metric listed in subsection (b) from the
- 1604 dashboard unless prohibited by law to protect personal privacy. All data shall be
- 1605 presented in de-identified aggregate form.

1606 **SEC. 507. FAA TRAINING AND POLICY REFORM REQUIREMENTS.**

- 1607 a. Within 180 days of enactment, the FAA shall revise all internal policies, training
1608 materials, and medical certification guidance to comply with this Act.
- 1609 b. Mandatory training shall be provided to all staff involved in medical certification,
1610 including:
- 1611 1. Airman Medical Certification Division (AMCD) staff,
 - 1612 2. Regional Flight Surgeons,
 - 1613 3. Medical review personnel, and
 - 1614 4. All FAA contractors or third-party vendors issuing medical recommendations.
- 1615 c. Training shall include instruction on:
- 1616 1. Airman rights under this Act,
 - 1617 2. Due process and impartiality standards,
 - 1618 3. Scientific risk evaluation and diagnostic validity,
 - 1619 4. Recognizing and avoiding bias, retaliation, or religious coercion.
- 1620 d. All FAA medical contractors, including HIMS-trained AMEs, psychiatrists, and
1621 neuropsychologists, shall complete compliance training as a condition of continued
1622 referral eligibility.

1623 **SEC. 508. FAA PUBLIC FORUMS AND COMMUNITY FEEDBACK.**

- 1624 a. Within 1 year of enactment and annually thereafter, the FAA shall hold at least two
1625 public town halls or listening sessions (virtual or in-person) open to:
- 1626 1. Certified covered individuals and applicants,
 - 1627 2. Healthcare providers,
 - 1628 3. Unions and associations, and
 - 1629 4. Advocacy organizations.
- 1630 b. The purpose of these forums is to:
- 1631 1. Present FAA compliance efforts and implementation updates,
 - 1632 2. Collect feedback and grievances directly from affected airmen, and
 - 1633 3. Allow the public to propose policy improvements or raise systemic concerns.
- 1634 c. A summary of each session shall be recorded, anonymized, and published within 60
1635 days.
- 1636 d. IAMOC shall attend these sessions and may independently assess FAA responsiveness
1637 and issue follow-up recommendations.

1638 **SEC. 509. SAFETY-BASED JUSTIFICATION LIMITATIONS.**

- 1639 a. The FAA may not rely on generic or unsubstantiated safety claims to override covered
1640 individual medical evidence or prolong monitoring.
- 1641 b. Any adverse action taken under the justification of “safety” must:
- 1642 1. Be supported by clinical evidence of specific risk in the covered individual’s
1643 current health status,
- 1644 2. Reference the applicable regulatory or scientific basis, and
- 1645 3. Be subject to appeal through the Independent Medical Review Board (IMRB).

1646 **SEC. 510. MODERNIZATION OF FAA AEROMEDICAL COMMUNICATION AND**
1647 **TECHNOLOGY SYSTEMS**

- 1648 a. Mandate for Modernization.
- 1649
- 1650 1. Within 18 months of enactment, the Federal Aviation Administration (FAA) shall
1651 replace all legacy aeromedical communication and certification systems—
1652 including but not limited to the Aerospace Medical Certification Subsystem
1653 (AMCS), the Aerospace Medical Information System (AMSIS), the Document
1654 Imaging Workflow System (DIWS), the Security Information System (SIS), the
1655 Designee Management System (DMS), and any other related technologies or
1656 databases used in the aeromedical certification process—with an integrated,
1657 secure, real-time digital infrastructure that supports transparency, timeliness,
1658 and access for all affected parties.
- 1659 b. System Requirements.
- 1660 1. The modernized system shall:
- 1661 a. Provide secure digital access to aeromedical certification records and
1662 real-time case status for all applicants, airmen, air traffic controllers, and
1663 authorized representatives;
- 1664 b. Issue immediate, electronic notifications of FAA decisions, information
1665 requests, submission deadlines, and status changes;
- 1666 c. Enable full interoperability between all FAA offices involved in medical
1667 certification, including those in Oklahoma City and Washington, D.C.;
- 1668 d. Provide AMEs with a secure portal to submit documentation, receive
1669 updates, and communicate with FAA medical personnel;

- 1670 e. Permit certificate holders to upload and retrieve documentation with
1671 timestamped confirmations of receipt;
- 1672 f. Provide data export functionality for use by the Independent Medical
1673 Review Board (IMRB), IAMOC, and airmen in appeal or audit processes;
- 1674 g. Ensure that all historic certification records and case data are preserved
1675 and digitally migrated into the new system;
- 1676 h. Meet or exceed federal standards for cybersecurity and data privacy,
1677 including FedRAMP certification or equivalent;
- 1678 i. Be accessible via both desktop and mobile platforms, with user
1679 interfaces designed to meet accessibility and usability standards;
- 1680 j. Undergo third-party usability testing and achieve a minimum
1681 satisfaction rating of 80% from each user group (airmen, AMEs,
1682 authorized reps) within 12 months of full deployment.
- 1683 c. Discontinuation of Paper-Based Communication.
- 1684 1. No later than 24 months after enactment, the FAA shall cease all non-requested
1685 paper-based correspondence related to aeromedical certification decisions,
1686 deferrals, requests, or appeals, unless explicitly requested in writing by the
1687 applicant or legally required.
- 1688 d. Oversight and Public Reporting.
- 1689 1. IAMOC shall oversee implementation and submit quarterly reports to Congress
1690 for the first three years, covering:
- 1691 a. System deployment progress and milestone adherence;
- 1692 b. Security testing results and incident disclosures;
- 1693 c. User access and functionality assessments;
- 1694 d. System outages or communication failures;
- 1695 e. Recommendations for further improvement.
- 1696 2. IAMOC shall have the authority to issue public notices of FAA noncompliance
1697 and recommend legislative remedies or administrative actions in cases of
1698 material delay or deviation from this section.
- 1699 e. User Engagement and Transparency.
- 1700 1. A permanent FAA Aeromedical Communication User Panel shall be established,
1701 composed of certificated individuals, AMEs, and advocacy organizations. The
1702 panel shall:

- 1703 a. Provide continuous feedback on platform performance and usability;
- 1704 b. Participate in scheduled reviews of proposed system updates or policy
- 1705 changes;
- 1706 c. Publish public reports summarizing recommendations and FAA
- 1707 responses.
- 1708 f. Mandatory Launch and Availability.
- 1709 1. The FAA shall launch a fully operational, publicly accessible digital portal for
- 1710 airmen and certificate holders no later than 30 months after enactment. The
- 1711 portal must meet the functional criteria listed in subsection (b) and be available
- 1712 to all U.S.-based applicants.
- 1713 g. Admissibility of Electronic Records.
- 1714 1. All system-generated correspondence, notifications, submission timestamps,
- 1715 and certification records shall be deemed admissible in legal proceedings and
- 1716 administrative appeals as official FAA records.
- 1717 h. Budget Transparency.
- 1718 1. Any contracts or expenditures related to system modernization exceeding
- 1719 \$250,000 shall be published on a public-facing FAA transparency portal,
- 1720 including vendor, scope of work, amount, and delivery deadlines.

1721 **SEC. 511. PROTECTIONS AND ACCOUNTABILITY FOR HOTLINE COMPLAINTS**

- 1722 a. Establishment of Safeguards for Hotline Complaints.
- 1723 1. The Administrator shall develop and implement formal procedures to ensure the
- 1724 fair, transparent, and accountable handling of any complaint or report received via
- 1725 FAA hotlines, employer hotlines, or other confidential reporting channels, including
- 1726 but not limited to reports concerning airman conduct, certification, or compliance.
- 1727 b. Minimum Standards for Complaint Handling.
- 1728 1. The procedures under subsection (a) shall, at minimum, require:
- 1729 a. Prompt Notification.
- 1730 The subject of a complaint shall be notified within 10 business days of receipt of
- 1731 any complaint that affects their certificate, medical qualification, or employment
- 1732 eligibility, except where disclosure would compromise an active criminal
- 1733 investigation. If the Administrator withholds notification under this subsection,
- 1734 a written justification shall be prepared and reviewed by the Independent

1735 Aeromedical Oversight Council within 30 days to confirm the necessity of
1736 nondisclosure. No notification delay shall exceed 60 days absent a court order.

1737 b. Specific Disclosure.

1738 The notification shall include:

1739 (i) The nature of the complaint in sufficient detail to allow for a meaningful
1740 response.

1741 (ii) The originating date of the report.

1742 (iii) The procedural status of the investigation.

1743

1744 c. Timely Resolution.

1745 (i) All complaints shall be resolved within 90 calendar days unless an extension
1746 is justified in writing by the Administrator and provided to the subject party.

1747 c. Prohibition on Reliance Without Corroboration.

1748 1. Standard of Evidence.

1749 No adverse action shall be taken against any airman based solely on an unverified or
1750 uncorroborated complaint.

1751 2. Requirement for Independent Corroboration.

1752 Any adverse action shall be supported by independent, material evidence that
1753 substantiates the substance of the complaint beyond mere assertion.

1754 3. Definition.

1755 For purposes of this section, "independent, material evidence" shall not include
1756 anonymous hearsay, uncorroborated impressions of behavior, or speculative
1757 assessments absent objective supporting documentation or direct observation by a
1758 qualified professional.

1759 4. Prohibition on Interim Measures.

1760 No interim suspension, grounding, employment restriction, or other adverse
1761 measure shall be imposed solely based on an unverified complaint absent evidence
1762 meeting the standard of paragraph (2).

1763 5. Documentation.

1764 Prior to taking action, the Administrator shall prepare a written record identifying
1765 the evidence relied upon, which shall be disclosed to the affected individual.

1766 d. False or Malicious Complaints.

- 1767 1. Any individual or entity found to have knowingly submitted a false, fraudulent, or
1768 malicious complaint shall be subject to:
- 1769 a. Civil penalties as prescribed under 49 U.S.C. §46301.
1770 b. Referral to appropriate licensing boards or authorities.
1771 c. Potential loss of participation privileges in FAA-recognized reporting programs.
- 1772 e. Confidential Reporting Protections.
- 1773 1. Complaints shall be recorded with identifying information secured.
1774 2. The subject shall be granted access to:
- 1775 a. A redacted version of the complaint sufficient to understand and rebut the
1776 allegations.
1777 b. Assurance that the identity of the complainant is protected consistent with
1778 applicable whistleblower protections, unless the complaint is determined to be
1779 knowingly false or malicious.
- 1780 f. Model After Established Programs.
- 1781 1. Procedures developed shall be substantially similar in principle to the Aviation
1782 Safety Action Program (ASAP) and NASA's Aviation Safety Reporting System (ASRS),
1783 whereby:
- 1784 a. Reports are confidential and non-punitive when submitted in good faith.
1785 b. Data is used to improve system safety and fairness, not as a disciplinary tool
1786 unless deliberate wrongdoing is established.
1787 c. The rights of airmen are preserved and balanced against legitimate safety
1788 objectives.
- 1789 g. Appeals and Oversight.
- 1790 1. An airman subject to adverse action based on a hotline complaint shall have the
1791 right to:
- 1792 a. Appeal the action to the Independent Aeromedical Oversight Council established
1793 under this Act.
1794 b. An expedited review of the underlying evidence and procedural compliance.
1795 c. A determination as to whether the action was supported by clear and convincing
1796 evidence beyond uncorroborated allegation.
1797 d. Any action taken in violation of this section, including failure to provide timely
1798 notification or evidence disclosure, shall be deemed procedurally invalid and

1799 subject to immediate reversal by the Independent Aeromedical Oversight
1800 Council.

1801 h. Protection Against Retaliation.

1802 1. No agency, employer, union, or contractor shall retaliate against any covered
1803 individual for:

1804 a. Contesting the validity of a complaint;

1805 b. Exercising rights under this section;

1806 c. Filing a grievance, appeal, or complaint related to any hotline allegation.

1807 2. Violations shall be subject to remedies including immediate reinstatement,
1808 damages, and referral for sanction under this Act.

1809 **SEC. 512. PROHIBITION ON REGULATORY PARTICIPATION IN INDUSTRY-AFFILIATED**
1810 **AEROMEDICAL PROGRAMS.**

1811 a. Prohibition on FAA Participation.

1812 Officers, employees, and agents of the Federal Aviation Administration involved in
1813 aeromedical certification may not—

1814 1. Participate in, present at, or otherwise engage in any educational, training, or
1815 professional event that is funded, sponsored, or materially supported by any entity
1816 providing aeromedical evaluation, monitoring, or treatment services;

1817 2. Accept compensation, honoraria, travel, lodging, or any thing of value in connection
1818 with such events;

1819 3. Provide official or unofficial endorsement of any such entity, program, or event.

1820 b. Prohibition on Adoption of Industry Frameworks.

1821 The Federal Aviation Administration may not—

1822 1. Rely upon, incorporate, or promote clinical frameworks, treatment models, or
1823 evaluative standards developed by entities with a Material Relationship to
1824 aeromedical monitoring or treatment services;

1825 2. Condition certification outcomes, physician participation, or program eligibility on
1826 adherence to such frameworks.

1827 c. Enforcement.

1828 IAMOC shall have authority to investigate violations of this section and invalidate any
1829 aeromedical determination influenced by prohibited participation or reliance.

1830 **SEC. 513. MANDATED PEER REVIEW AND ETHICAL COMPLIANCE OVERSIGHT.**

- 1831 a. Independent Peer Review Requirement.
- 1832 The aeromedical decision-making practices of the Federal Aviation Administration shall
- 1833 be subject to ongoing independent peer review to ensure compliance with established
- 1834 scientific and ethical standards governing medical practice.
- 1835 b. Scope of Review.
- 1836 Peer review under this section shall include evaluation of—
- 1837 1. Clinical decision-making methodologies;
- 1838 2. Adherence to evidence-based medical standards;
- 1839 3. Consistency with accepted ethical frameworks, including those recognized by the
- 1840 American Psychiatric Association and the American Academy of Psychiatry and the
- 1841 Law.
- 1842 c. Oversight Authority.
- 1843 IAMOC shall—
- 1844 1. Conduct or oversee such peer review;
- 1845 2. Identify deviations from accepted medical standards;
- 1846 3. Require corrective action where deficiencies are identified.
- 1847 d. Investigatory Authority.
- 1848 IAMOC may initiate investigations into potential violations of medical ethics by FAA
- 1849 physicians or affiliated evaluators and issue findings and recommendations.

1850 **SEC. 514. PHYSICIAN PROTECTION AND PROHIBITION ON RETALIATION.**

- 1851 a. Protection of Independent Medical Judgment.
- 1852 No physician or medical professional shall be subject to adverse action for—
- 1853 1. Providing an independent medical opinion;
- 1854 2. Disagreeing with FAA determinations;
- 1855 3. Following evidence-based clinical practices.
- 1856 b. Prohibited Conduct by the FAA.
- 1857 The Federal Aviation Administration and its agents may not—
- 1858 1. Threaten, intimidate, or coerce any physician in connection with aeromedical
- 1859 decision-making;
- 1860 2. Remove, restrict, or refuse designation based on disagreement with FAA-preferred
- 1861 conclusions;
- 1862 3. Engage in blacklisting, reputational harm, or informal exclusion of physicians
- 1863 providing independent opinions.

1864 c. Enforcement.
1865 IAMOC shall have authority to review allegations of retaliation and order appropriate
1866 remedies, including reinstatement of designation and invalidation of affected
1867 determinations.

1868 **SEC. 515. PHYSICIAN-REQUESTED CASE CONFERENCES AND RECORDING**
1869 **REQUIREMENTS.**

- 1870 a. Right to Request Conference.
1871 A Covered Individual, or a treating physician acting on behalf of a Covered Individual,
1872 may request a case conference regarding any pending aeromedical determination.
- 1873 b. Required Participants.
1874 The Federal Aviation Administration shall ensure participation by—
1875 1. The FAA physician responsible for the determination;
1876 2. The treating physician or requesting physician;
1877 3. One or more independent, board-certified physicians in fields pertinent to the case,
1878 where requested.
- 1879 c. Recording Requirement.
1880 All case conferences conducted under this section shall be audio recorded in full and
1881 preserved as part of the administrative record.
- 1882 d. Access and Use.
1883 The Covered Individual and participating physicians shall have access to such
1884 recordings, which shall be admissible in any administrative, appellate, or judicial
1885 proceeding.
- 1886 e. Enforcement.
1887 Failure to provide a requested conference or to comply with this section shall constitute
1888 a procedural deficiency subject to review and potential invalidation by IAMOC.

1889 **TITLE VI — DEFINITIONS AND EFFECTIVE DATES**

1890 **SEC. 601. DEFINITIONS.**

- 1891 a. **AEROPath.**
1892 The Aviation Evaluation and Recovery Oversight Pathway, an alternative to the HIMS
1893 Program created under this Act. AEROPath is independently governed, science-based,
1894 and non-coercive.

- 1895 b. **Airman.**
- 1896 Any individual holding or applying for an FAA certificate under 14 CFR Parts 61, 63, or
- 1897 65, including but not limited to covered individuals (student, recreational, private,
- 1898 commercial, and ATP), air traffic control specialists, flight engineers, aircraft
- 1899 dispatchers, and mechanics.
- 1900 c. **Appeal.**
- 1901 Any process by which a covered individual challenges a medical determination,
- 1902 including IMRB review, FAA reconsideration, or NTSB appeal under 49 U.S.C. § 44703.
- 1903 d. **Case Conference.**
- 1904 A structured discussion involving Federal Aviation Administration medical personnel
- 1905 and one or more physicians regarding a specific aeromedical determination, conducted
- 1906 for the purpose of reviewing medical evidence, clinical reasoning, and certification
- 1907 decisions.
- 1908 e. **Chain of Custody.**
- 1909 A documented process that tracks sample collection, handling, and analysis to ensure
- 1910 integrity and allow covered individual review.
- 1911 f. **Coercive Treatment.**
- 1912 Any mandated participation in recovery or support programs without a valid diagnosis,
- 1913 due process, and the covered individual's informed consent.
- 1914 g. **Commencement of Monitoring Period.**
- 1915 The term "commencement of monitoring period" means the earliest date determined
- 1916 under Section 715(b), including any date of first documented abstinence, recovery
- 1917 engagement, or the date of first FAA intervention.
- 1918 h. **Conflict of Interest.**
- 1919 Any personal, financial, or institutional relationship that could compromise impartiality
- 1920 in certification, evaluation, or monitoring decisions.
- 1921 i. **Contemporaneous Evidence.**
- 1922 The term "contemporaneous evidence" means any record, report, notation, declaration,
- 1923 or testimony created at or reasonably reflecting the relevant time period, regardless of
- 1924 when such documentation is submitted to the FAA, provided that it credibly supports
- 1925 the existence of abstinence, treatment engagement, or recovery efforts.
- 1926 j. **Contractor.**
- 1927 Any individual or organization acting on behalf of the FAA or under FAA authorization

1928 to evaluate, treat, test, or monitor a covered individual for medical certification
1929 purposes.

1930 k. **Covered Individual.**

1931 Any person subject to, applying for, or previously subject to FAA medical certification,
1932 clearance, monitoring, or aeromedical evaluation. This includes covered individuals,
1933 student covered individuals, air traffic controllers, flight attendants, mechanics,
1934 maintenance technicians, dispatchers, FAA-designated medical professionals, applicants
1935 for certification or reentry, and any individual referred for evaluation under FAA
1936 jurisdiction or policy.

1937 l. **Date of First FAA Intervention.**

1938 The term “date of first FAA intervention” means the earliest date on which the Federal
1939 Aviation Administration issued any written notice, request, or communication
1940 indicating that the covered individual would be subject to monitoring, evaluation,
1941 Special Issuance conditions, or medical review as a result of a disqualifying event or
1942 condition.

1943 m. **Due Process.**

1944 The guaranteed right of any covered individual to receive timely written notice, review
1945 all evidence, respond before enforcement, access appeal mechanisms, and be free from
1946 arbitrary or retaliatory action.

1947 n. **FAA Contractor Accountability.**

1948 All rights, remedies, and penalties in this Act apply equally to contractors, designees,
1949 and other FAA-affiliated third parties involved in certification or oversight.

1950 o. **FAA Designee.**

1951 Any individual authorized by the FAA to conduct or recommend evaluations,
1952 monitoring, or certification decisions, including AMEs, treatment providers, and
1953 psychiatrists.

1954 p. **FAA File.**

1955 The complete medical record maintained by the FAA for any airman, including internal
1956 communications, test results, case notes, third-party documentation, contractor
1957 evaluations, and case logs.

1958 q. **FAA Medical Appeals Board (FMAB).**

1959 Any internal FAA body created to review medical determinations shall be subject to the

1960 procedural and transparency requirements of this Act and may not replace the IMRB or
1961 NTSB.

1962 r. **HIMS Program.**

1963 The legacy FAA Human Intervention Motivation Study program for covered individuals
1964 with a history of substance use or mental health conditions. Phased out under this Act.

1965 s. **IAMOC (Independent Aeromedical Oversight Council).**

1966 The oversight body established under Title V to monitor FAA compliance, receive
1967 complaints, and publish annual trend reports.

1968 t. **IMRB (Independent Medical Review Board).**

1969 A three-member panel established under Section 202 to hear and decide covered
1970 individual appeals of FAA medical denials or restrictions.

1971 u. **Independent Physician.**

1972 A physician who—

1973 1. Holds active board certification in a medical specialty relevant to the case under
1974 review; and

1975 2. Has no Material Relationship with—

1976 a. The Federal Aviation Administration; or

1977 b. Any entity providing aeromedical evaluation, monitoring, or treatment services
1978 related to the Covered Individual.

1979 v. **Industry-Funded Event.**

1980 Any educational, training, or professional event that is funded, sponsored, or materially
1981 supported, in whole or in part, by any entity that provides aeromedical evaluation,
1982 monitoring, treatment, consulting, or related services to Covered Individuals.

1983 w. **International Pilot.**

1984 A non-U.S. citizen operating U.S.-registered aircraft or flying in U.S. airspace under FAA
1985 medical jurisdiction. Fully protected under this Act when subject to FAA certification or
1986 monitoring.

1987 x. **Laboratory Accreditation.**

1988 Refers to certification by SAMHSA, CLIA, or CAP. All FAA-accepted labs must maintain
1989 current accreditation.

1990 y. **Material Harm.**

1991 Includes grounding, certification denial or delay, job loss, reputational damage, income
1992 loss, or loss of bid or seniority status due to FAA or contractor action.

- 1993 z. **Material Interruption.**
- 1994 The term “material interruption” means a verified occurrence of resumed substance use
- 1995 or noncompliance of such frequency or severity that it would reasonably interrupt the
- 1996 continuous nature of abstinence or recovery efforts, and which is established by clear
- 1997 and convincing evidence.
- 1998 aa. **Material Relationship.**
- 1999 Any financial, contractual, advisory, or professional relationship that could reasonably
- 2000 be expected to influence clinical judgment or regulatory decision-making, including
- 2001 compensation, referral arrangements, consulting agreements, participation in
- 2002 sponsored programs, or any relationship creating the appearance of a conflict of
- 2003 interest.
- 2004 ab. **Monitoring.**
- 2005 Any ongoing testing, treatment, observation, or reporting requirement tied to an
- 2006 airman’s medical certification, whether imposed by FAA, employer, union, or third
- 2007 party.
- 2008 ac. **Neuropsychological Evaluation.**
- 2009 A cognitive assessment conducted by a licensed psychologist trained in
- 2010 neuropsychology. Must be individualized, clinically justified, and cannot be used for
- 2011 blanket exclusion.
- 2012 ad. **Peer Review.**
- 2013 Independent medical review conducted by professionals not involved in the covered
- 2014 individual’s case and without financial or institutional conflict of interest.
- 2015 ae. **Retaliation.**
- 2016 Any adverse action taken in response to a covered individual’s protected activity under
- 2017 this Act, including whistleblowing, filing a complaint, or requesting review.
- 2018 af. **Rights Notification.**
- 2019 The formal written document outlining covered individual rights under this Act,
- 2020 required to be delivered with any FAA action that imposes monitoring, denial, or
- 2021 deferral.

2022 ag. **Scientific Validity.**
2023 The requirement that any medical or behavioral decision be based on peer-reviewed
2024 evidence, DSM-5-TR criteria, and accepted clinical standards.

2025 ah. **Scope of Protections.**
2026 All rights, safeguards, access to appeals, and procedural requirements under this Act
2027 shall apply equally to certificated individuals regardless of employment status,
2028 including student covered individuals, recreational aviators, general aviation
2029 participants, and individuals seeking reentry or certification for the first time.

2030 ai. **Special Issuance (SI).**
2031 Any certificate issued under 14 CFR § 67.401 or similar discretionary FAA medical
2032 authorization that imposes conditions, restrictions, or monitoring requirements.

2033 **SEC. 602. EFFECTIVE DATES.**

2034 a. This Act shall take effect 90 days after enactment, unless otherwise specified herein.

2035 b. The FAA shall issue interim implementation guidance within 120 days, and finalize
2036 revised medical certification regulations within 180 days of enactment.

2037 c. The secure FAA covered individual portal required under Section 501 shall be
2038 operational no later than 12 months after enactment.

2039 d. The Independent Medical Review Board (IMRB) and Independent Oversight Council
2040 (IAMOC) shall be fully operational within 6 months.

2041 e. AEROPath shall begin covered individual enrollment within 12 months, begin accepting
2042 HIMS transitions within 18 months, and replace the HIMS Program entirely by 24
2043 months post-enactment.

2044 f. Any FAA delay in implementing this Act that causes material harm to a covered
2045 individual may be subject to civil remedy under Title VII.

2046 **TITLE VII — ADDITIONAL PROTECTIONS, AUTHORITIES, AND ENFORCEMENT**

2047 **SEC. 701. CIVIL ENFORCEMENT AND PRIVATE RIGHT OF ACTION.**

2048 a. Private Right of Action.

- 2049 1. Any covered individual who suffers harm as a result of a violation of this Act
2050 may bring a civil action in any U.S. District Court for:
- 2051 a. Declaratory and injunctive relief;
 - 2052 b. Reinstatement or correction of FAA records;
 - 2053 c. Compensatory and punitive damages.
- 2054 2. Covered violations include but are not limited to:
- 2055 a. Coercive treatment without diagnosis or due process;
 - 2056 b. Denial or delay of certification based on undisclosed, non-medical, or
2057 retaliatory factors;
 - 2058 c. Violations of privacy, evaluator choice, or monitoring limits;
 - 2059 d. Interference with appeal rights, IAMOC access, or IMRB proceedings.
- 2060 b. Statute of Limitations.
- 2061 1. Any civil action under this section must be filed within two years of the date the
2062 covered individual knew or reasonably should have known of the violation.
- 2063 c. Burden of Proof.
- 2064 1. In any claim brought under this Act, the burden shall rest on the FAA or
2065 affiliated defendant to show by clear and convincing evidence that any
2066 challenged action was:
- 2067 a. Medically necessary,
 - 2068 b. Consistent with statutory and regulatory authority, and
 - 2069 c. Undertaken without retaliation, conflict of interest, or deviation from
2070 due process.
- 2071 d. Protection from Retaliation.
- 2072 1. It shall be unlawful for the FAA, an employer, a contractor, or a union to take any
2073 adverse action against a covered individual for:
- 2074 a. Filing a complaint under this Act;
 - 2075 b. Requesting a second opinion or IMRB review;
 - 2076 c. Refusing religious, ideological, or unsupported treatment;
 - 2077 d. Engaging in protected speech about program experiences.
- 2078 2. Retaliation includes:
- 2079 a. Suspension, grounding, or delay of certification;
 - 2080 b. Threats, blacklisting, or surveillance;
 - 2081 c. Removal from seniority rosters or bid access;

- 2082 d. Employer-initiated medical referrals based on non-clinical behavior or
2083 advocacy.
- 2084 e. Attorneys' Fees.
- 2085 1. Prevailing covered individuals under this section shall be entitled to reasonable
2086 attorneys' fees, expert costs, and court costs.
- 2087 f. Scope of Liability.
- 2088 1. This section applies to:
- 2089 a. The FAA and all affiliated divisions;
- 2090 b. Designees, contractors, and treatment providers acting under FAA authority;
- 2091 c. Employers or unions that interfere with medical access, choice, or rights.
- 2092 2. IAMOC shall maintain jurisdiction over all complaints filed under this section
2093 and may refer patterns of abuse to the Department of Justice or Office of
2094 Inspector General.

2095 **SEC. 702. CONTRACTOR AND DESIGNEE LIABILITY.**

- 2096 a. Any FAA-authorized contractor, AME, evaluator, or treatment provider shall be treated
2097 as an agent of the FAA for enforcement under this Act.
- 2098 b. These individuals or entities may be held liable if they:
- 2099 1. Participate in coercive, retaliatory, or unsupported actions;
- 2100 2. Submit materially false or misleading documentation to the FAA;
- 2101 3. Violate a covered individual's rights under this Act.
- 2102 c. FAA affiliation shall not be grounds for immunity in civil or administrative actions.

2103 **SEC. 703. PROHIBITION ON WAIVER OR SUPPRESSION OF RIGHTS.**

- 2104 a. No policy, agreement, contract, or form may limit, waive, or suppress rights guaranteed
2105 under this Act.
- 2106 b. Covered individuals may not be required to forfeit rights to appeal, representation, or
2107 second opinion as a condition of certification, treatment, or employment.
- 2108 c. Any attempt to coerce such waiver is void and shall trigger investigation by IAMOC and
2109 potential contractor decertification.

2110 **SEC. 704. RULEMAKING AND INTERIM AUTHORITY.**

- 2111 a. The FAA shall revise all relevant regulations, advisory circulars, and internal guidance
2112 within 180 days of enactment.
- 2113 b. Until such rules are finalized, this Act shall be treated as binding law and enforced
2114 accordingly.
- 2115 c. FAA personnel, contractors, and designees shall comply with this Act from the date of its
2116 effective implementation under Section 602.

2117 **SEC. 705. PREEMPTION OF CONFLICTING LAW.**

- 2118 a. This Act supersedes and preempts any conflicting FAA order, internal policy, advisory
2119 circular, or administrative interpretation.
- 2120 b. No collective bargaining agreement, state law, or employer directive may restrict or
2121 delay enforcement of the rights set forth in this Act.
- 2122 c. This shall not prevent additional protections adopted by states or unions that enhance
2123 covered individual rights.

2124 **SEC. 706. SEVERABILITY.**

- 2125 a. If any part of this Act is held invalid or unenforceable, the remainder shall remain in full
2126 effect.

2127 **SEC. 707. ENFORCEMENT TRIGGER AND PENALTY MECHANISM.**

- 2128 a. If the FAA fails to implement AEROPath, the IMRB, or the secure portal within the
2129 timelines of Title VI, covered individuals may seek injunctive relief and statutory
2130 damages.
- 2131 b. A pattern of noncompliance may trigger DOT Inspector General investigation and
2132 formal notice to Congress with recommendation for administrative oversight or
2133 intervention.

2134 **SEC. 708. RETALIATION PENALTIES AND MANDATORY INVESTIGATION.**

2135 a. Verified findings of retaliation against a covered individual for asserting rights under
2136 this Act shall result in:

2137 1. Double statutory damages (up to \$500,000);

2138 2. Mandatory IMRB case freeze or expedited reinstatement;

2139 3. FAA review of involved personnel or contractors within 30 days.

2140 b. IAMOC shall maintain a public record of verified retaliation cases, anonymized by
2141 default.

2142 **SEC. 709. FAA ANNUAL COMPLIANCE CERTIFICATION.**

2143 a. The Federal Air Surgeon shall file an annual sworn compliance statement with IAMOC
2144 and Congress certifying that all FAA aeromedical guidance, decisions, and policies
2145 remain in full compliance with this Act.

2146 b. IAMOC may investigate and publish discrepancies if the certification is found to be
2147 inaccurate, incomplete, or misleading.

2148 **SEC. 710. NOTIFICATION TO AFFECTED COVERED INDIVIDUALS IN CASE OF**
2149 **VIOLATION.**

2150 a. Any finding by the IMRB, IAMOC, or DOT Inspector General that a violation of this Act
2151 affected a specific covered individual shall require written notification to the airman
2152 within 10 business days.

2153 b. The notification must include:

2154 1. Description of the violation;

2155 2. Corrective steps or appeal rights;

2156 3. Access to legal aid resources.

2157 c. Failure to notify the affected covered individual shall be considered a secondary
2158 violation and may entitle the airman to additional damages.

2159 **SEC. 711. CONGRESSIONAL FUNDING FOR COVERED INDIVIDUAL LEGAL AND MEDICAL**
2160 **AID.**

2161 a. Congress shall authorize appropriations to support legal, clinical, and advocacy services
2162 assisting covered individuals in navigating medical certification disputes and appeals
2163 under this Act.

2164 b. Services may include:

2165 1. Pro bono or low-cost legal representation;

2166 2. Independent medical evaluations;

2167 3. Expert witness testimony;

2168 4. Rights education and case navigation.

2169 c. IAMOC shall coordinate with the DOT and legal aid networks to develop a covered
2170 individual assistance framework within 12 months of enactment.

2171 **SEC. 712. FAA SYSTEMIC MISCONDUCT SANCTION THRESHOLD.**

2172 a. If IAMOC finds that more than 5% of covered individual cases annually contain
2173 confirmed violations of this Act, it shall issue a Systemic Misconduct Finding.

2174 b. This finding shall:

2175 1. Be reported to Congress and DOT OIG;

2176 2. Trigger formal FAA leadership review;

2177 3. Require immediate compliance plan submission.

2178 c. IAMOC shall publicly publish the results of the finding, and Congress may initiate
2179 oversight hearings or administrative restructuring as needed.

2180 **SEC. 713. WHISTLEBLOWER PROTECTIONS.**

2181 a. Protected Activity.

2182 1. No FAA employee, contractor, union, employer, or designee may retaliate
2183 against a covered individual for engaging in any of the following protected
2184 activities:

2185 a. Reporting violations of this Act to IAMOC, the FAA, Congress, or any
2186 oversight body;

- 2187 b. Participating in any investigation, hearing, or proceeding under this Act;
- 2188 c. Communicating publicly, anonymously, or through counsel about
- 2189 experiences within FAA medical oversight programs;
- 2190 d. Refusing to comply with unlawful, unscientific, religiously coercive, or
- 2191 retaliatory directives.

2192 b. Scope of Protection.

2193 1. Protected individuals include:

- 2194 a. Current and former covered individuals;
- 2195 b. Witnesses, experts, advocates, or attorneys representing a covered
- 2196 individual;
- 2197 c. FAA employees or contractors who report wrongdoing within the
- 2198 agency or its designees.

2199 c. Remedies.

2200 1. Any person or entity found to have retaliated against a whistleblower shall be

2201 subject to:

- 2202 a. Immediate injunctive relief to halt further harm;
- 2203 b. Full backpay, restoration of lost certification or seniority, and correction
- 2204 of all FAA and employer records;
- 2205 c. Civil penalties up to \$100,000 per incident;
- 2206 d. Mandatory referral to the Department of Transportation Office of
- 2207 Inspector General and/or the Office of Special Counsel.

2208 d. Anti-Gag Clause.

- 2209 1. No nondisclosure agreement, internal policy, or employment contract may
- 2210 prevent a covered individual from disclosing violations of this Act or
- 2211 participating in reform efforts.

2212 e. IAMOC Authority.

2213 1. IAMOC shall:

- 2214 a. Establish a secure online portal for anonymous complaints;
- 2215 b. Investigate whistleblower claims within 90 days;
- 2216 c. Refer credible patterns of abuse to Congress or the Department of
- 2217 Justice.

2218 **SEC. 714. BAN ON RELIGIOUS COERCION AND FORCED IDEOLOGY.**

- 2219 a. Prohibited Conduct.
- 2220 1. No FAA employee, contractor, AME, treatment provider, employer, or union may
- 2221 mandate, encourage, or condition certification or employment on participation
- 2222 in religious or ideological activities, including but not limited to:
- 2223 a. Twelve-step programs that require acknowledgment of a “Higher
- 2224 Power”;
- 2225 b. Religious services, prayer, scripture readings, or spiritual counseling;
- 2226 c. Affirmations, confessions, or other acts of faith;
- 2227 d. Religious literature or symbols presented as mandatory recovery
- 2228 material.
- 2229 b. Rights of Covered Individuals.
- 2230 1. Covered individuals shall have the right to opt out of any treatment, meeting, or
- 2231 support group that includes religious or spiritual content.
- 2232 2. Secular alternatives must be made available at equal standing and without
- 2233 delay, stigma, or penalty.
- 2234 3. No individual shall be labeled “noncompliant,” “resistant,” or “lacking buy-in”
- 2235 based on a refusal to engage in religious practices.
- 2236 c. Enforcement.
- 2237 1. Any violation of this section shall be deemed discrimination and coercion under
- 2238 this Act.
- 2239 2. Covered individuals may file complaints with IAMOC or pursue civil remedies
- 2240 under Section 701.
- 2241 3. All designees, evaluators, and programs must certify annually that they comply
- 2242 with this section as a condition of FAA recognition.
- 2243 d. IAMOC Oversight.
- 2244 1. IAMOC shall:

- 2245 a. Develop a reporting system to track incidents of religious coercion;
- 2246 b. Audit treatment and support programs for compliance;
- 2247 c. Refer egregious violations to the Department of Justice for civil rights
- 2248 enforcement.

2249

2250 **SEC. 715. MONITORING DURATION LIMITS AND SUNSET RULES.**

2251 a. Maximum Monitoring Period.

2252 1. No covered individual may be subject to FAA-imposed monitoring, treatment,

2253 reporting, or certification conditions for longer than:

- 2254 a. Five (5) years total for any continuous period of FAA-imposed oversight related
- 2255 to substance use, mental health, or behavioral concerns—regardless of the
- 2256 number of alleged incidents, evaluations, or diagnoses within that period—
- 2257 beginning from the commencement of the monitoring period as defined in
- 2258 subsection b;
- 2259 b. Two (2) years if no diagnosis of substance dependence or disqualifying mental
- 2260 health condition was made by an independent evaluator;
- 2261 c. One (1) year if the individual has had no prior history, no incident involving a
- 2262 safety risk, and has complied fully with all initial requirements.

2263 b. Commencement of Monitoring Period.

2264 1. For purposes of this section, the monitoring period shall begin on the earliest of:

- 2265 a. The date the covered individual first demonstrates or documents sustained
- 2266 abstinence or recovery efforts related to the condition at issue, as evidenced by:
- 2267 (i) Enrollment in a treatment or recovery program;
- 2268 (ii) Participation in a peer support or recovery program with documentation;
- 2269 (iii) Medical or counseling records indicating abstinence or treatment
- 2270 compliance; or
- 2271 (iv) A sworn declaration of abstinence or recovery engagement corroborated by
- 2272 contemporaneous evidence;
- 2273 b. The date of first FAA intervention, defined as the earliest date on which the FAA
- 2274 issued any written notice, request, or communication indicating that monitoring,
- 2275 evaluation, or Special Issuance would be required.

- 2276 c. Automatic Termination and Record Removal.
- 2277 1. All FAA monitoring conditions, Special Issuances, and related reporting obligations
- 2278 shall:
- 2279 a. Terminate automatically upon reaching the applicable maximum duration,
- 2280 without need for additional application, appeal, or re-justification;
- 2281 b. Be removed from the FAA medical record and replaced with a statement of
- 2282 medical eligibility, unless clear and convincing evidence demonstrates an active
- 2283 disqualifying condition within the preceding 12 months.
- 2284 d. No Open-Ended or Indefinite Monitoring.
- 2285 1. The FAA shall not impose or maintain any:
- 2286 a. Rolling monitoring periods that restart upon administrative error, discretionary
- 2287 reassessment, or procedural delays;
- 2288 b. Indefinite or discretionary renewals without new, individualized clinical
- 2289 findings and IAMOC review;
- 2290 c. Certification delays based solely on elapsed time in treatment or pending
- 2291 paperwork.
- 2292 e. Presumption of Validity.
- 2293 1. In the absence of clear and convincing evidence to the contrary, documented
- 2294 abstinence or recovery efforts shall be presumed valid and shall be credited toward
- 2295 the applicable monitoring duration.
- 2296 2. Documented initiation of abstinence shall be presumed continuous absent clear and
- 2297 convincing evidence of a material interruption.
- 2298 f. Exceptions.
- 2299 1. The above limits may be extended by no more than twelve (12) months total if:
- 2300 a. A covered individual experiences a documented clinical relapse that creates a
- 2301 material safety concern; and
- 2302 b. The extension is approved by both the Independent Medical Review Board
- 2303 (IMRB) and IAMOC, based on new evidence.
- 2304 g. IAMOC Oversight.
- 2305 1. IAMOC shall:
- 2306 a. Maintain a registry of all FAA-imposed monitoring periods by role and
- 2307 condition;
- 2308 b. Publish annual statistics on durations, renewals, and sunset compliance;

- 2309 c. Refer violations or patterns of excessive monitoring to Congress and the
2310 Department of Transportation.
- 2311 h. Protection of Credit for Early Abstinence and Recovery.
- 2312 1. No delay in the submission of documentation shall alter or delay the
2313 commencement of the monitoring period, provided the documentation reliably
2314 demonstrates the date of abstinence or recovery initiation.
- 2315 2. A declaration or record referencing an earlier date of abstinence or recovery
2316 initiation shall be sufficient to establish the commencement date if corroborated by
2317 any evidence described in this section.
- 2318 3. For purposes of this subsection, “contemporaneous evidence” shall include any
2319 record, report, notation, or testimony created at or reasonably reflecting the
2320 relevant time period, regardless of when such documentation is submitted.
- 2321 4. Any period during which the covered individual engages in documented abstinence
2322 or recovery efforts reasonably related to anticipated FAA review or certification
2323 requirements shall be deemed part of the continuous period of oversight.

2324 **SEC. 716. PROTECTIONS FOR REENTRY AND MEDICAL REINSTATEMENT.**

- 2325 a. Right to Reapply Without Prejudice.
- 2326 1. Any individual whose medical certificate has lapsed, been revoked, or
2327 voluntarily surrendered may reapply for FAA medical certification without
2328 being automatically labeled high-risk, treatment-resistant, or noncompliant —
2329 unless supported by clear and convincing evidence of current impairment.
- 2330 b. Limits on Historic Penalties.
- 2331 1. The FAA shall not:
- 2332 a. Deny or delay certification based on past monitoring noncompliance,
2333 insurance lapse, or paperwork deficiencies older than five (5) years,
2334 unless they pose a current safety risk;
- 2335 b. Reopen or reuse closed cases to justify new monitoring periods without
2336 new clinical evidence;
- 2337 c. Require full program repetition for previously treated, cleared, and
2338 medically eligible individuals.

- 2339 c. Reentry Evaluation Standards.
- 2340 1. Individuals seeking reentry after more than two (2) years away from monitoring
2341 shall undergo a single evaluation by an independent, FAA-authorized medical
2342 examiner;
- 2343 2. If medically cleared, they may be certified without further treatment or long-
2344 term monitoring, unless disqualifying factors are identified.

2345 d. IAMOC Review and Oversight.

- 2346 1. IAMOC shall track trends in reentry denials and delays;
- 2347 2. Investigate any systemic patterns of unnecessary barriers to return;
- 2348 3. Recommend procedural changes annually to ensure fairness and reintegration.

2349 **SEC. 717. EMPLOYER INTERFERENCE AND RETALIATION PROHIBITION.**

2350 a. Prohibited Conduct.

- 2351 1. No employer, airline, chief covered individual, union representative, or medical
2352 coordinator may:
- 2353 a. Attempt to override, delay, or interfere with an airman's FAA medical
2354 certification process;
- 2355 b. Submit false or misleading information to the FAA regarding an airman's
2356 compliance or fitness;
- 2357 c. Threaten, discipline, or penalize an airman for asserting their rights
2358 under this Act or for maintaining medical privacy;
- 2359 d. Condition employment, reinstatement, or seniority on the waiver of
2360 rights guaranteed by this Act.

2361 b. Medical Privacy Safeguards.

- 2362 1. Employers may verify current medical certification status, but may not require
2363 access to Special Issuance terms, treatment history, or underlying medical
2364 records unless explicitly authorized by the airman;
- 2365 2. Any retaliatory action taken in response to a refusal to disclose protected
2366 medical information shall constitute unlawful retaliation.

2367 c. IAMOC Enforcement.

- 2368 1. IAMOC shall accept and investigate complaints of employer interference or
2369 retaliation;
- 2370 2. IAMOC may issue findings, refer violations to the Department of Labor, and
2371 require corrective actions or policy changes;
- 2372 3. Repeated or egregious interference may result in IAMOC's public referral of the
2373 employer or union to Congress or DOT.
- 2374 d. Civil Remedies.
- 2375 1. Any airman harmed by employer retaliation or interference may seek:
- 2376 a. Reinstatement of job position and seniority;
- 2377 b. Compensation for lost wages or benefits;
- 2378 c. Attorneys' fees and punitive damages, if malice or gross negligence is
2379 proven.

2380 **SEC. 718. FAMILY RIGHTS AND CAREGIVER PROTECTIONS.**

- 2381 a. Right to Family Stability.
- 2382 1. The FAA shall not impose medical certification conditions that:
- 2383 a. Require separation from family or home life unless justified by
2384 individualized, documented clinical necessity;
- 2385 b. Mandate inpatient treatment in a facility over 100 miles from the
2386 airman's residence without express consent;
- 2387 c. Interfere with parenting, caregiving, or employment responsibilities
2388 without a compelling safety-based justification.
- 2389 b. Respect for Marital and Parental Roles.
- 2390 1. Married airmen may not be penalized for requesting local care, outpatient
2391 alternatives, or home-based monitoring accommodations;
- 2392 2. Parenting duties, including shared custody or caregiving of dependents, shall be
2393 considered in all treatment planning and FAA expectations.
- 2394 c. Optional Family Involvement.
- 2395 1. Spouses, partners, and family members may voluntarily participate in support
2396 or education programs, but shall not be required to do so as a condition of the
2397 airman's certification;
- 2398 2. No FAA form or evaluator may demand written statements, surveillance, or
2399 loyalty declarations from family members.

- 2400 d. IAMOC Monitoring.
- 2401 1. IAMOC shall:
- 2402 a. Monitor FAA and contractor policies for patterns that unduly burden
- 2403 families;
- 2404 b. Issue an annual review of treatment placement trends, geographic
- 2405 burdens, and family hardship complaints;
- 2406 c. Refer violators or systemic problems to the DOT Office of Civil Rights or
- 2407 Congress.

2408 **SEC. 719. SUNSET OF MEDICAL LABELS.**

- 2409 a. Expiration of Disqualifying Labels.
- 2410 1. Any designation applied to a covered individual by the FAA — including but not
- 2411 limited to “substance dependent,” “alcohol dependent,” “mentally unfit,”
- 2412 “noncompliant,” or “high-risk” — shall expire after five (5) consecutive years of
- 2413 full medical eligibility and abstinence, unless reaffirmed by clear and convincing
- 2414 current clinical evidence.
- 2415 b. Prohibition on Reuse.
- 2416 1. The FAA may not reuse or reassert a prior disqualifying label to justify new
- 2417 monitoring, denial, or treatment requirements unless:
- 2418 a. New, individualized clinical evidence has emerged;
- 2419 b. The covered individual has had a verified relapse or disqualifying event;
- 2420 c. The individual is actively applying for a new class of certification
- 2421 requiring updated evaluation.
- 2422 c. Application to Historical Cases.
- 2423 1. This section shall apply retroactively. Any covered individual previously labeled
- 2424 disqualified based on a historical incident shall be deemed cleared of that label
- 2425 five years after the last date of active monitoring or disqualification, if no new
- 2426 safety concerns have arisen.

2427 **TITLE VIII — LONG-TERM OVERSIGHT, MODERNIZATION, AND CONTINUITY**

2428 **SEC. 801. COVERED INDIVIDUAL’S BILL OF RIGHTS (APPENDIX A REFERENCE).**

2429 a. The Covered individual's Bill of Rights, attached as Appendix A, shall be considered an
2430 enforceable supplement to this Act. It must be provided in writing whenever the FAA
2431 initiates:

2432 1. Deferral,

2433 2. Denial,

2434 3. Special Issuance,

2435 4. Monitoring, or

2436 5. Any action triggering covered individual appeal or second opinion.

2437 b. Failure to provide the Bill of Rights shall invalidate the related action until it is properly
2438 issued.

2439 **SEC. 802. INDEPENDENT EVALUATION REGISTRY.**

2440 a. The FAA shall maintain and publicly publish a registry of independent evaluators
2441 approved for use by covered individuals seeking second opinions or non-HIMS
2442 evaluations. This registry shall include:

2443 1. Board-certified psychiatrists,

2444 2. Licensed neuropsychologists,

2445 3. Addiction medicine physicians, and

2446 4. Occupational health experts.

2447 b. The following individuals shall be ineligible for inclusion:

2448 1. Those with active HIMS affiliations,

2449 2. Those receiving FAA referral compensation, and

2450 3. Those subject to conflict-of-interest findings by IAMOC.

2451 c. IAMOC shall audit the registry annually and may remove providers upon receiving
2452 complaints, conflict disclosures, or scientific misconduct reports.

2453 **SEC. 803. MANDATORY SUNSET REVIEW.**

2454 a. Within 7 years of enactment, IAMOC shall conduct a Sunset Review of this Act and its
2455 implementation. The review shall assess:

- 2456 1. Covered individual outcomes and reinstatement rates,
- 2457 2. Certification delay reductions,
- 2458 3. Contractor and designee conduct,
- 2459 4. Retaliation incident frequency, and
- 2460 5. Scientific consistency with current clinical standards.

2461 b. IAMOC shall submit a public Sunset Review Report to Congress, including any
2462 recommended amendments, reauthorizations, or repeals.

2463 **SEC. 804. FEDERAL AVIATION MENTAL HEALTH REFORM COMMISSION.**

2464 a. Congress shall seat a Federal Aviation Mental Health Reform Commission within 6
2465 months of this Act's enactment. The Commission shall operate for a period of 5 years.

2466 b. Membership shall include:

- 2467 1. Three covered individuals with lived experience under FAA monitoring,
- 2468 2. Two clinical psychologists with aviation experience,
- 2469 3. One civil liberties or disability rights expert,
- 2470 4. One representative of the DOT Inspector General (non-voting), and
- 2471 5. One FAA medical officer (non-voting liaison).

2472 c. The Commission shall meet quarterly and issue biannual public reports on:

- 2473 1. Aviation mental health best practices,
- 2474 2. Scientific innovation,
- 2475 3. Alternatives to coercive recovery models, and

2476 4. Industry and FAA culture reform.

2477 d. Reports shall be submitted to Congress and made publicly available on the FAA's
2478 website.

2479 **SEC. 805. REAUTHORIZATION AND MODERNIZATION PROVISION.**

2480 a. If this Act is not reauthorized or amended by Congress within 10 years of enactment,
2481 IAMOC shall submit a Modernization Report including:

2482 1. Summary of legal, scientific, or operational barriers,

2483 2. Stakeholder feedback from covered individuals and clinicians, and

2484 3. Legislative recommendations for reauthorization or replacement.

2485 b. This report shall serve as the formal starting point for statutory renewal.

2486 **SEC. 806. PROHIBITION ON REACTIVATION OF LEGACY MONITORING PROGRAMS.**

2487 a. No legacy monitoring program, including the HIMS Program, shall be reactivated or
2488 expanded following enactment of this Act, except by express act of Congress.

2489 **Appendix A — Covered individual's Bill of Rights**

2490 a. **Due Process:**

2491 1. You have the right to receive written notice of any adverse FAA certification
2492 action.

2493 2. You have the right to access your complete FAA medical file, including all
2494 internal notes and third-party reports.

2495 3. You may respond to allegations, submit supporting evidence, and request
2496 review or appeal.

2497 b. **Freedom from Coercion:**

2498 1. You may not be forced into religious, 12-step, or spiritually based programs.

2499 2. Treatment may only be imposed with a valid DSM-5-TR diagnosis and your
2500 informed consent.

2501 3. FAA personnel and contractors may not retaliate against you for exercising your
2502 rights.

2503

2504

2505 c. **Transparency and Timelines:**

2506 1. The FAA must provide real-time access to your medical case status through a
2507 secure online portal.

2508 2. The FAA must meet strict timelines for processing, notifying, and responding to
2509 your submissions.

2510 3. Delays or missing updates may entitle you to legal remedy and case tolling.

2511 d. **Fair Scientific Standards:**

2512 1. All evaluations and diagnoses must follow current scientific and clinical best
2513 practices.

2514 2. You may seek a second medical opinion using an independent, conflict-free
2515 provider.

2516 3. Monitoring programs may not exceed 36 months unless there is a verified
2517 relapse.

2518 e. **Financial Protections:**

2519 1. You cannot be required to pay for treatment, testing, or evaluation without
2520 medical justification.

2521 2. You have access to a federal hardship reimbursement fund to offset monitoring-
2522 related expenses.

2523 3. If wrongfully grounded, you are entitled to backpay, benefit restoration, and
2524 legal restitution.

2525 f. **Right to Appeal:**

- 2526 1. You may challenge any FAA action through the Independent Medical Review
2527 Board (IMRB).
- 2528 2. Emergency reviews must be heard within 10 business days.
- 2529 3. You retain all rights to pursue further appeal to the NTSB or federal court.

2530 g. **Whistleblower and Advocacy Protection:**

- 2531 1. You are protected from retaliation for reporting misconduct, coercion, or FAA
2532 violations.
- 2533 2. You may publicly or privately advocate for reform without certification
2534 consequences.
- 2535 3. IAMOC has the authority to investigate retaliation claims and publish findings.

2536 h. **Notification and Correction:**

- 2537 1. You must be informed of all rights listed here when facing FAA medical action.
- 2538 2. If these rights are not disclosed to you at the time of deferral or denial, any
2539 resulting action shall be suspended until corrected.

2540

2541 **This document shall be delivered with:**

2542 Any Special Issuance notice

2543 Any monitoring enrollment order

2544 Any deferral, denial, or proposed adverse action

2545 Any referral to a contractor, evaluator, or treatment provider affiliated with an FAA-

2546 governed monitoring program, including the legacy HIMS Program or any successor

2547 program such as AEROPath